

67 2501

BALTIMORE CITY HEALTH DEPARTMENT

67 2501

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DOUGLAS

RUFFIN

2. DATE AND HOUR PRONOUNCED DEAD

March 11, 1967

10:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

438 E. 20th Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED

8. DATE OF BIRTH

10-14-05

9. AGE (In years
lost birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

453-05-3580

17. INFORMANT

ADDRESS

Mrs. Lillian B. Pollard 438 E. 20th st.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gun Shot Wound of Chest.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Ashburton St. & North Avenue 15-06

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 11 '67 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-14-67

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l Cem.

23D. LOCATION

(City, town, or county)

Baltimore, M

(State)

24A. DATE REC'D BY HEALTH DEPT.

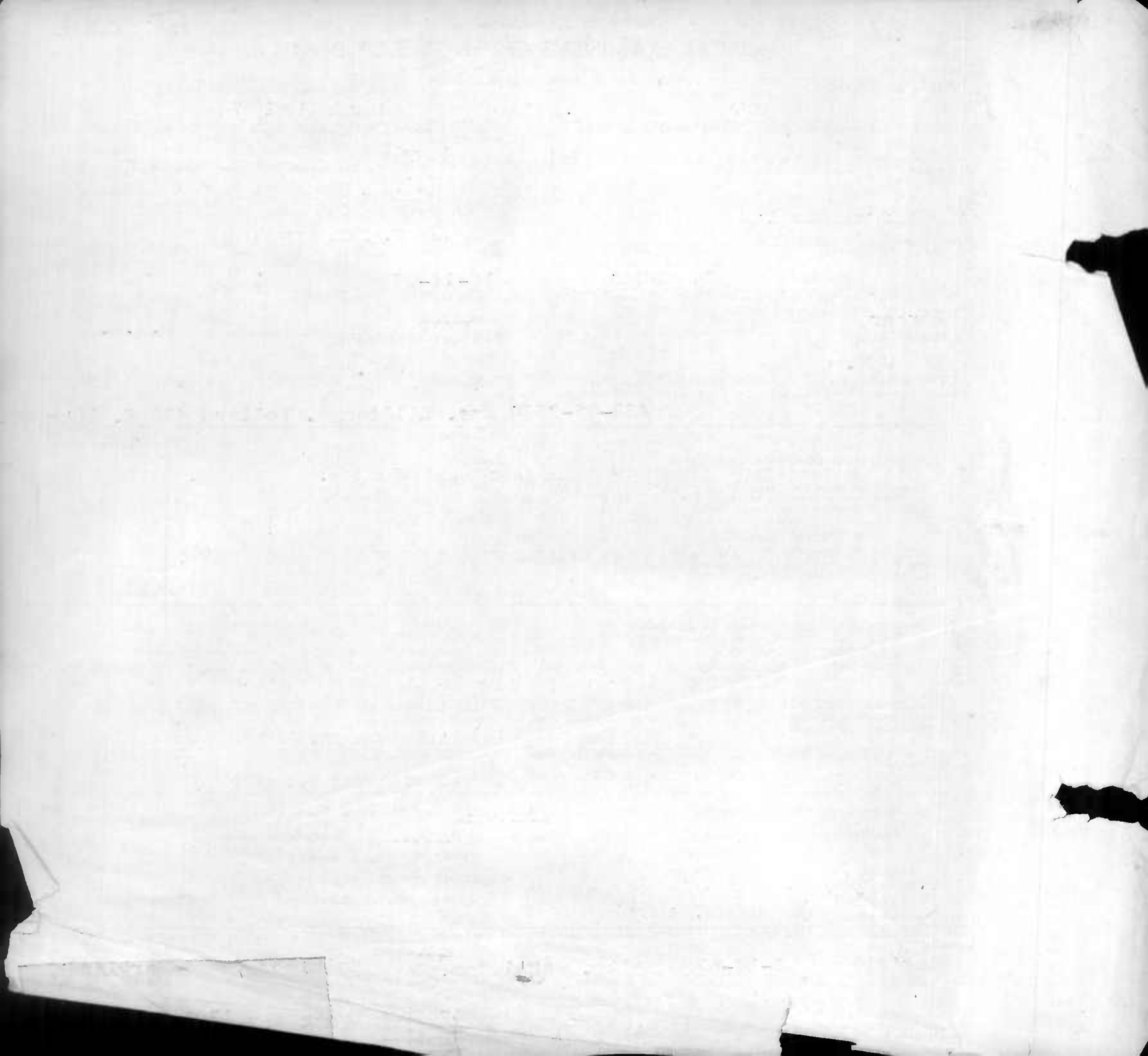
MAR 14 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Morton & Dy



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2502		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2502	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Shelton, MARTHA</i>			2. DATE AND HOUR OF DEATH <i>3-11-67 10:00 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Frederick</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>LINCOLN MEMORIAL NURSING HOME, 27 N. CAREY ST. BALTIMORE, MARYLAND. 21223.</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Frederick Ave. Balto.</i>		
D. STREET ADDRESS (If rural, give location) <i>18-01</i>					
5. SEX <i>F.</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED</i> , DIVORCED (specify)	B. DATE OF BIRTH <i>5/27/1889</i>	9. AGE (In years lost birthday) <i>77</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>A.A. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>MAK CARTER</i>			14. MOTHER'S MAIDEN NAME <i>HARRIETT A. TURNER</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Rebecca Lee</i>		ADDRESS <i>1411 Bloomingdale Rd.</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <i>CEEBRAL VASCULAR ACCIDENT</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/27/67</i> 19 to <i>3/11/67</i> 19 that (I) (we) last saw the deceased alive on <i>3/11/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>3/11/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>WILLIAM SENNAHIVE</i>		23D. ADDRESS <i>930 WHITE ROCK ST. BALTO. MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>3-14-67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Marion E. Dyett F.H.</i>	
				ADDRESS <i>1701 Lawrence St.</i>	

~~CONFIDENTIAL~~

Attn: Mr. James F. W. - 153



79 9 1 2

Case No. 100-100000

3/11/5

12/10/5

3/11/5

[Handwritten signature]

James F. W.

Mr. James F. W.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 67 2503					
BIRTH NO. 67 2503		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) TINNEN, Virgil Francis			2. DATE AND HOUR OF DEATH March 12, 1967 3:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218					A. STATE Washington, D.C. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington, D.C. V-48 D. STREET ADDRESS (If rural, give location) Apt. 2 4236 6th Street, S.E.					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 1/27/08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John					14. MOTHER'S MAIDEN NAME Jennie Brown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11/22/43 to 11/23/45			16. SOCIAL SECURITY NO. 577-16-6785		17. INFORMANT Veterans Hospital Records ADDRESS 3900 Loch Raven Blvd, Baltimore, Md. 21218					
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis					(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO					
					(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from March 3, 19 67 to March 12, 19 67 , that (2) (we) lost saw the deceased alive on March 12, 19 67 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.										
23A. SIGNATURE Robert R. Kent M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 3/13/67		
23C. PHYSICIAN'S NAME (Type) Robert R. Kent M.D.					23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Md. 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-67		24C. NAME of CEMETERY or CREMATORY Alexander Nat'l Cem.		24D. LOCATION (City, town, or county) (State) Alexandria, Va.				
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Frazier F.H. 389 Rhode Island N					

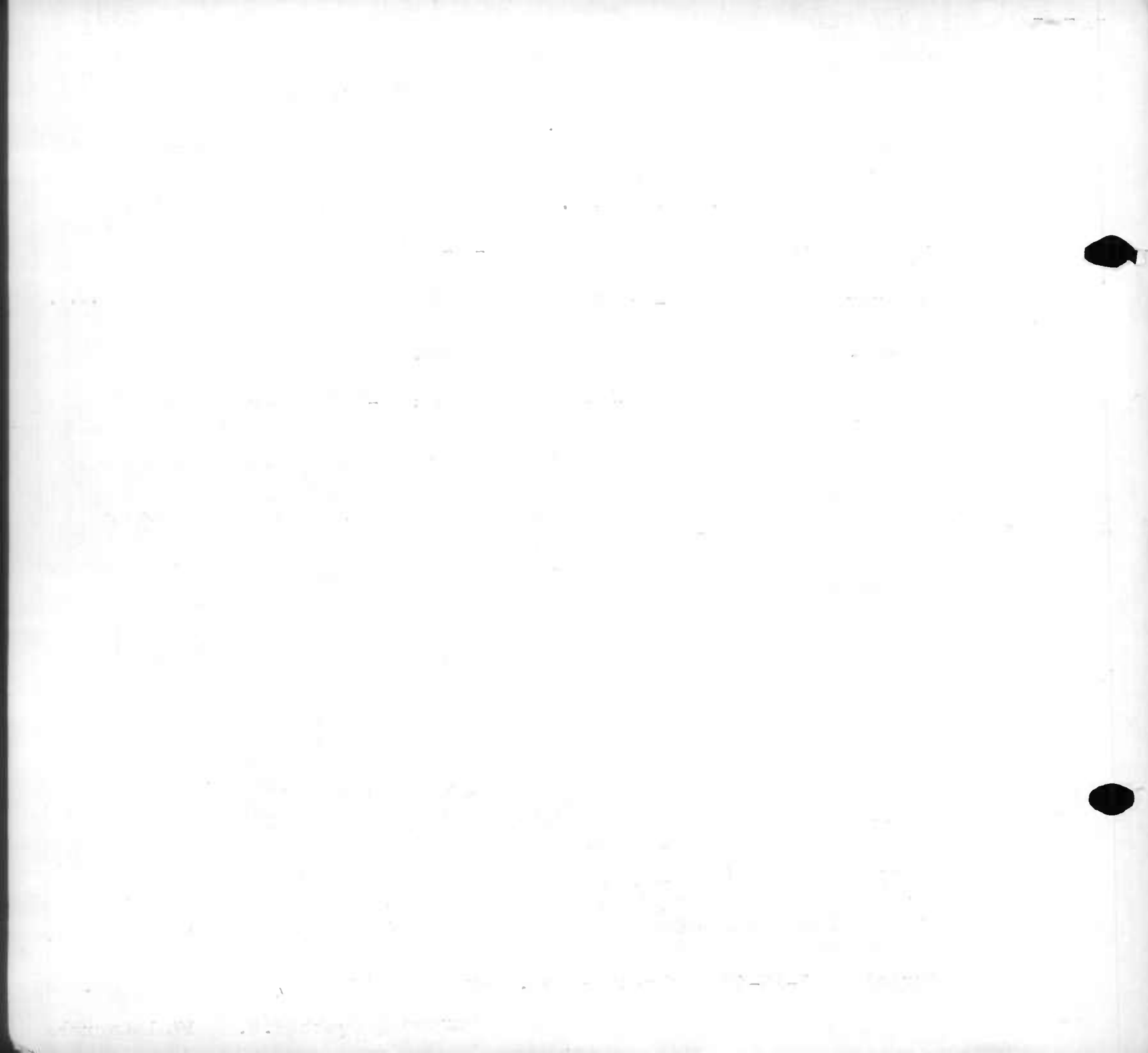


SAB-48-65-63
M68863

FUNERAL DIRECTOR: IMPORTANT

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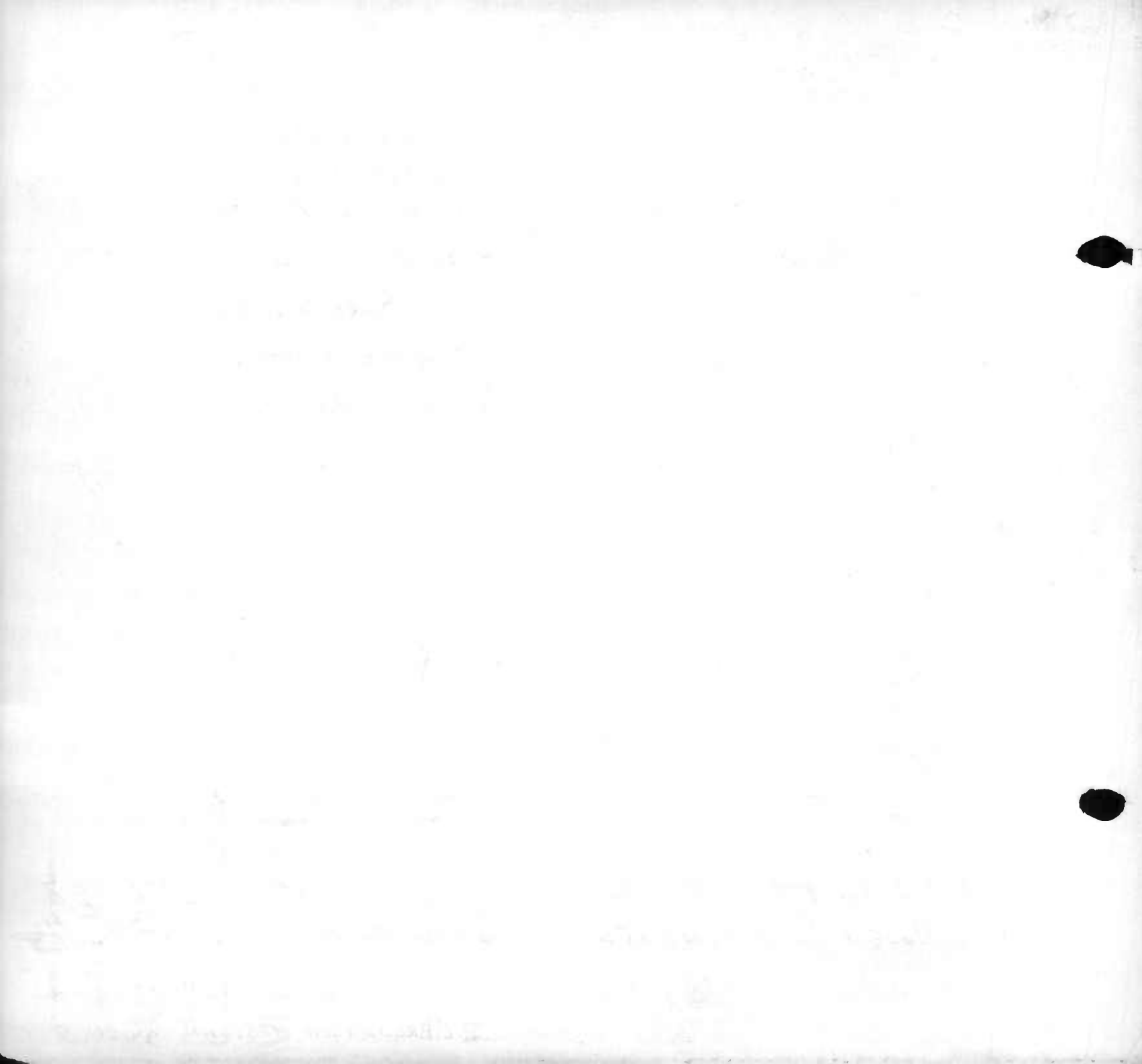
BIRTH NO. 67 2504		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2504	
M.E. CASE NO. 48-65-63		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MURRAY John		2. DATE AND HOUR OF DEATH 3/9/67 6:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
31 Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md.		Maryland 15-06			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1700 Poplar Grove Street 21217			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-15-1894	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Unk.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-7473		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. 443XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Multiple Pulmonary emboli		INTERVAL BETWEEN ONSET AND DEATH months.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) HASC RD, multiple		? years	
		(C) CVA's		? years	
		A zotema 2 to B.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/6/67 to 3/9/67, that (I) (we) lost saw the deceased alive on 3/9/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Terry Ersel Gagon		M.D. Attending Phys. Med. Director Staff Phys. 4		23B. DATE SIGNED 3/9/67	
23C. PHYSICIAN'S NAME (Type) Terry Ersel Gagon		23D. ADDRESS M.O. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR Morton & Dyett F.H.	
				1701 Laurens	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 2505					Registered No. 67 2505				
1. NAME OF DECEASED (Type or Print) <i>OTis Wright</i>					2. DATE AND HOUR OF DEATH <i>3-6-1967 1:50 P. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>43 South Baltimore General Hosp.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>21-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21230</i> D. STREET ADDRESS (If rural, give location) <i>1030 W. Barre St.</i>				
5. SEX <i>M.</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>	8. DATE OF BIRTH <i>4-26-1900</i>	9. AGE (In years last birthday) <i>66</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>L</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Sam Hardy</i>					14. MOTHER'S MAIDEN NAME <i>Bessie Wright</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Westbrook</i>			ADDRESS <i>-124 W. Cross</i>	
18. <i>493 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
19. <i>493 X I</i> DISEASE OR CONDITION CAUSING IT (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i>					INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initiate medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <i>3-2</i> 19 <i>67</i> to <i>3-6</i> 19 <i>67</i> , that the (we) last saw the deceased alive on <i>3-6</i> 19 <i>67</i> and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>COLEN C. REINERTZ</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-10-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>COLEN C. REINERTZ</i>					23D. ADDRESS <i>SOUTH BALTIMORE GENERAL HOSP.</i>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			24B. DATE <i>3/11/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>mt Auburn</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1967</i>			25B. NAME OF REGISTRAR <i>P. D. G. E. Taylor</i>			25C. FUNERAL DIRECTOR <i>D. L. Brownson</i>			
						ADDRESS <i>108 W. Montgomery St.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 2506	
BIRTH NO. 67 2506		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY W. PALMER		2. DATE AND HOUR OF DEATH 3-12-67 9:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
LUTHERAN HOSPITAL OF MARYLAND		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		2018 N. SMALLWOOD ST			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 11-24-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				N. Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Thomas Palmer 2018 Smallwood	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO CVA			
ANTECEDENT CAUSES		(B) DUE TO Chronic, Pneumonia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes Mellitus, Hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-4-67 to 3-12-67, that (I) (we) lost saw the deceased alive on 3-12-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas C. Vidhyaphum M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3-12-67	
23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDHYAPHUM M.D.				23D. ADDRESS Lutheran Hospital of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 3-13-67		24C. NAME OF CEMETERY or CREMATORY Haliloh	
24D. LOCATION (City, town or county) (State)		24E. NAME OF REGISTRAR Robert E. Jackson		24F. FUNERAL DIRECTOR R. J. Collick 2431 E. Oliver St.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

W. C. C. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2507	
BIRTH NO. 67 2507		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Dyer, John (John Dyer)		2. DATE AND HOUR OF DEATH 3-11-67 5:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 10-01			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 1-18-05		9. AGE (In years lost birthday) 62		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alfred Dyer - CHRIS DYER			
14. MOTHER'S MAIDEN NAME Fanny Lee		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-03-7967		17. INFORMANT ADDRESS BC# 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224			
18. 1929 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Ca ? Salivary gland Primary		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 yrs duration	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10-20-1966 to 3-11-1967 , that (we) last saw the deceased alive on 3-11-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE A. P. Weinfeld		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-11-67	
23C. PHYSICIAN'S NAME (Type) A. P. Weinfeld		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk. Arbutus, Maryland	
24D. LOCATION (City, town, or county) (State) Baltimore, Md. #21224					
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR R. E. Farber		25C. FUNERAL DIRECTOR Randolph J. Collick 2431 E. Oliver St.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2508		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2508	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ISAAC NELSON (ISAAC NELSON)		3-12-67-		12 ³⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Ben-Wil-Ba Convalescent 2101 W. Cold Spring Lane		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-15 D. STREET ADDRESS (If rural, give location) 2101 W. Cold Spring Lane			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed.	8. DATE OF BIRTH 8-1-96	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Howard Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Isaac Nelson		14. MOTHER'S MAIDEN NAME Harriet Francis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-67-6159	17. INFORMANT May Thomas		ADDRESS Paradise Ave
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis		CAUSE OF DEATH (A) Generalized arteriosclerosis DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-26- 1963 to 3-12- 1967 , that (I) (we) last saw the deceased alive on 3-8- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.R. Campbell		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-12-67	
23C. PHYSICIAN'S NAME (Type) C.R. Campbell		M.D. 23D. ADDRESS 1618 W. North Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/67		24C. NAME OF CEMETERY or CREMATORY Wester Star	
24D. LOCATION Baltimore Md		24E. NAME OF REGISTRAR Charles A. Rice		24F. FUNERAL DIRECTOR ADDRESS 661 W. Barre St	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2509		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2509	
M.E. CASE NO.			2		
1. NAME OF DECEASED (Type or Print) <i>Sandy Moore</i>			2. DATE AND HOUR OF DEATH <i>3-12-67</i> <i>2:45 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>BAR-Wil. BA Convalescent Home</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>17-01</i>		
(If not in hospital or institution, give street address or location) <i>2101 Coldspring Lane</i>			D. STREET ADDRESS (If rural, give location) <i>537 Moore Street</i>		
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>5-1-96</i>	9. AGE (In years lost birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>labor</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Mississippi</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>
13. FATHER'S NAME <i>Beverly</i>			14. MOTHER'S MAIDEN NAME <i>Anna</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> <i>WWI</i>		16. SOCIAL SECURITY NO. <i>240-094207</i>	17. INFORMANT <i>Catherine Moore</i> <i>1424 E. Lombard St</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <i>Arteriosclerotic heart disease</i> DUE TO (B) DUE TO (C)		
19. DATE OF OPERATION <i>0</i>			20A. AUTOPSY? (Yes or No) <i>No</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>12-18-1963</i> to <i>3-12-1967</i> , that (I) (we) last saw the deceased alive on <i>3-12-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>C.R. Campbell</i>			23B. DATE SIGNED <i>3-12-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>C.R. Campbell</i>			23D. ADDRESS <i>1618 W. North Ave. Baltimore, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/16/67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>MAR 14 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>	25C. FUNERAL DIRECTOR <i>Charles A. Rice</i> <i>661 W. Barre St</i>		

FUNERAL DIRECTOR: IMPORTANT

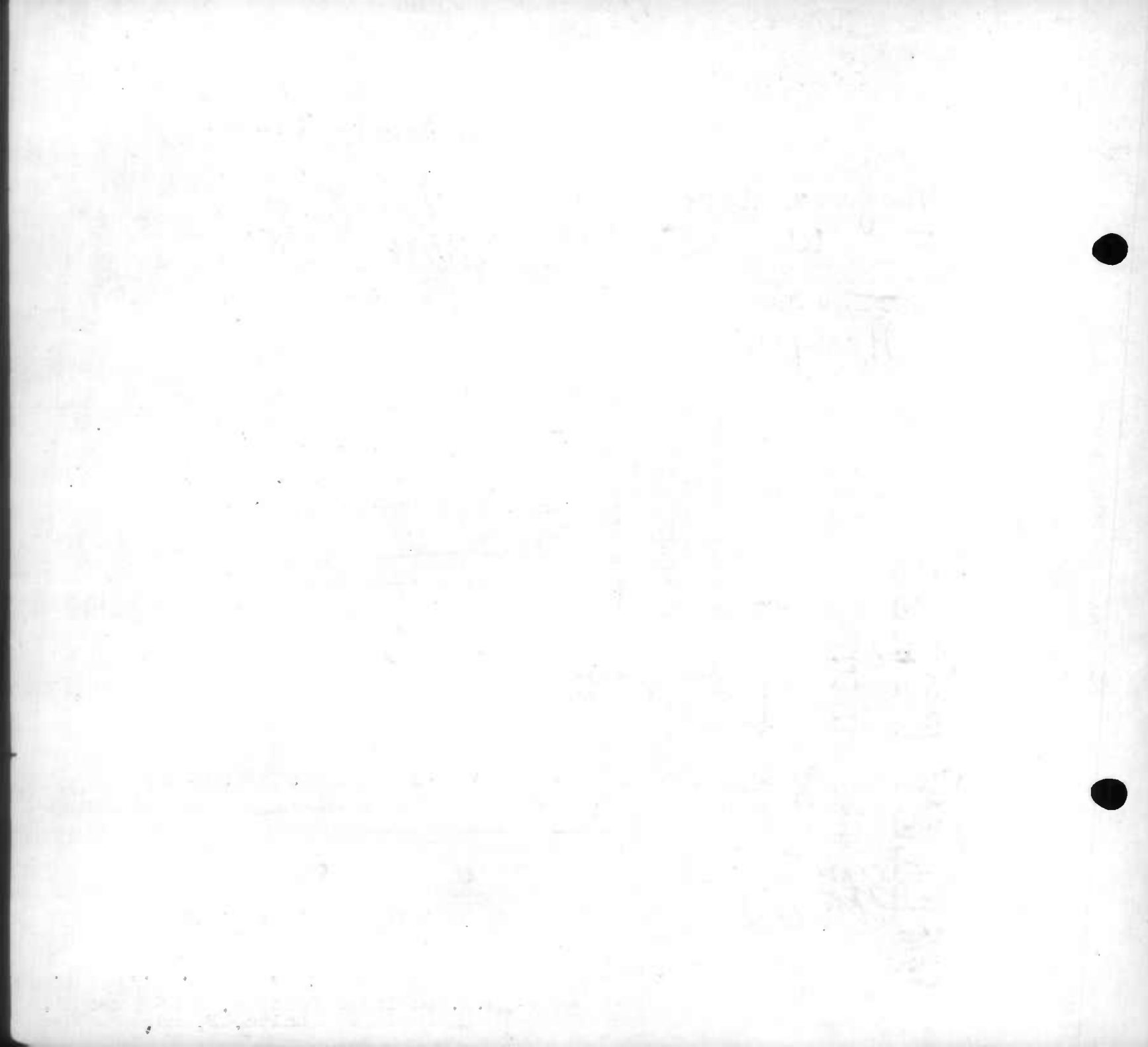
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2510	
BIRTH NO. 67 2510		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edward R. Case		2. DATE AND HOUR OF DEATH 3/13/67 530 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND Gen. Hosp		A. STATE Md. B. COUNTY 12 Church Warden Rd			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21212 27-12			
		D. STREET ADDRESS (If rural, give location) 212 Churchwardens Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED , DIVORCED (specify)	8. DATE OF BIRTH 7/12/1879	9. AGE (In year lost birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) N. Y.	
13. FATHER'S NAME Franklin Case		14. MOTHER'S MAIDEN NAME Clara Baxter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 150-07-3261		17. INFORMANT Mrs. Clara H. Nicoll ADDRESS (Same)	
18. 7-22-11		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO ASCVD			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Congestive Heart Failure			
		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 2/22 19 3/13 to 3/13 19 67 , that (X) (we) lost saw the deceased alive on 3/13/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.					
23A. SIGNATURE B. J. Baldwin M.D.				23B. DATE SIGNED 3/13/67	
23C. PHYSICIAN'S NAME (Type) BRIAN J Baldwin M.D.				23D. ADDRESS Maryland Gen. Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3-15-67		24C. NAME of CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore		24E. (City, town, or county) (State) Md			
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR P. E. E. F. E. E.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto., Md.	



REASON ON APPROVAL 187 20471202
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2511		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2511	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lee Edna M. McGraw		2. DATE AND HOUR OF DEATH 3/12/67 2:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital		A. STATE B. COUNTY Md. Balto 21212			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-09			
		D. STREET ADDRESS (If rural, give location) 1511 Penridge Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11/29/86	9. AGE (in years, lost birthday) 80	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Harry Mills		14. MOTHER'S MAIDEN NAME Georganna Ogile		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 319-28-7477		17. INFORMANT ADDRESS 5602 "C" Woodmont Ave (12) MRS. WILLIAM B. ARMIGER	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last.		CAUSE OF DEATH A. Anteriorly ruptured aorta (A) DUE TO PLEURAL EFFUSION AND CARDIAC CIRRHOSIS DUE TO AORTIC STENOSIS (CALCIFIC TYPE) (B) DUE TO (C) Fracture of Hg 4		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2/13/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fracture of Hg 4		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work [] Not While At Work []		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/4/67 19 to 3/12/67 19 that (I) (we) last saw the deceased alive on 3/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Brian J. Baldwin M.D. Attending Phys. [] Med. Director [] Stopped Phys. [X]				23B. DATE SIGNED 3/12/67	
23C. PHYSICIAN'S NAME (Type) Baldwin				23D. ADDRESS Maryland General Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/1967		24C. NAME of CEMETERY or CREMATORY Woodlawn	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
25A. DATE RECD BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR E. E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2512		Baltimore City Health Department CERTIFICATE OF DEATH		Registered No. 67 2512	
1. NAME OF DECEASED (Type or Print) Dominic A. Capezio			2. DATE AND HOUR OF DEATH 3/13/67 12:38 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2709 D. STREET ADDRESS (If rural, give location) 1535 KK Kingsway Rd.		
5. SEX M	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 7, 1896	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Capezio			14. MOTHER'S MAIDEN NAME Filomena Covila		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-1601	17. INFORMANT ADDRESS Angelina Capezio, 1535 Kingsway Rd.		
18. 260X I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Acute Myocardial Infarction (B) DUE TO Diabetes Mellitus 3 yrs (C) _____		
INTERVAL BETWEEN ONSET AND DEATH 1 hour					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Thrombosis					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/25/67 19 to 3/13/67 19, that (I) (we) lost saw the deceased alive on 2/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Davis				23B. DATE SIGNED 3-14-67	
23C. PHYSICIAN'S NAME (Type) John R. Davis, M. D.				23D. ADDRESS 401 Medical Arts Building	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3-17-67		Holy Redeemer	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967			
Balto., Md.		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>55-47-44</u>	
BIRTH NO. <u>67 2513</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Wentworth, Alexander W.</u>		2. DATE AND HOUR OF DEATH <u>March 13, 1967</u> <u>12³⁰ P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>33rd & Calvert Sts. Balto. Md. 21218</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21234</u> <u>53-00</u>	
D. STREET ADDRESS (If rural, give location) <u>3003 Woodside Avenue</u>							
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>Feb. 17, 1983</u>		9. AGE (In years last birthday) <u>84</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from ?</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Railway Express Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wentworth</u>				14. MOTHER'S MAIDEN NAME <u>Arlinda Underhill</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>714-03-4553</u>		17. INFORMANT <u>(Son) Michael E. Wentworth</u>		ADDRESS <u>2926 Willoughby Rd. Balto.</u>	
18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> <u>Coronary heart failure</u> <u>ASCVD</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>ME Jones</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 12, 1967</u> to <u>March 13, 1967</u> , that (I) (we) lost saw the deceased alive on <u>March 13, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sang-Kyun Shin</u> <u>SANG-KYUN SHIN</u> <u>Francis T. Daly</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>March 13, 1967</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/16/67.</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Stedman</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 2514					CERTIFICATE OF DEATH				
Registered No. 67 2514									
1. NAME OF DECEASED (Type or Print) MILLER, MARTIN L.					2. DATE AND HOUR OF DEATH MARCH 13TH '67 10³⁰ A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44					A. STATE MARYLAND B. COUNTY				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21211 13-07				
D. STREET ADDRESS (If rural, give location) 3622 BEECH AVENUE									
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-10 1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN Retired			10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN		
13. FATHER'S NAME JOHN MICHAEL MILLER					14. MOTHER'S MAIDEN NAME ANNA ZORBACH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army 1911 To 1914			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna V. Miller		ADDRESS (Same)		
18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PULMONARY EMPHYSEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
INTERVAL BETWEEN ONSET AND DEATH 10 YEARS									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3-2-8 19 67 to 3-13 19 67 , that (I) (we) last saw the deceased alive on 3-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Fred J. Ruck M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-13-67		
23C. PHYSICIAN'S NAME (Type) FRED JOHNSON BJORNSSON					23D. ADDRESS THE UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/67.		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967			25B. NAME OF REGISTRAR Robert E. Taney		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2515				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2515	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Philippe Mary O. PHILIPP</i>				2. DATE AND HOUR OF DEATH <i>3/13/67</i> <i>12 45 P</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>House in the Pines, Belvedere</i>				A. STATE <i>Md.</i> B. COUNTY			
5. SEX <i>F</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
6. RACE <i>can</i>				D. STREET ADDRESS (If rural, give location) <i>27-38</i> <i>6146 Loch Raven Blvd.</i>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>				8. DATE OF BIRTH <i>1/18/1885</i> 9. AGE (In years last birthday) <i>82</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Frank Rafferty</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Bandell</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>213-10-7089B</i>			
17. INFORMANT <i>Mr. George E. Philipp</i>				ADDRESS (Same)			
18. <i>4201 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>				CAUSE OF DEATH (A) DUE TO <i>Arteriosclerosis</i>			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 17 1967</i> to <i>Mar 13 1967</i> , that (I) (we) last saw the deceased alive on <i>Mar 10 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Lester N. Kolman M.D.</i>				23B. DATE SIGNED <i>3/13/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>LESTER N. KOLMAN M.D.</i>				23D. ADDRESS <i>3700 Park Heights Ave Baltimore, Md 21215</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/16/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Buck, Inc.</i>		ADDRESS <i>Balto. Md. 21214</i>	

ROCKEFELLER J. ARNOLD
 WHITE MALE
 319 KEYSTONE AVENUE
 BALTIMORE
 MARYLAND

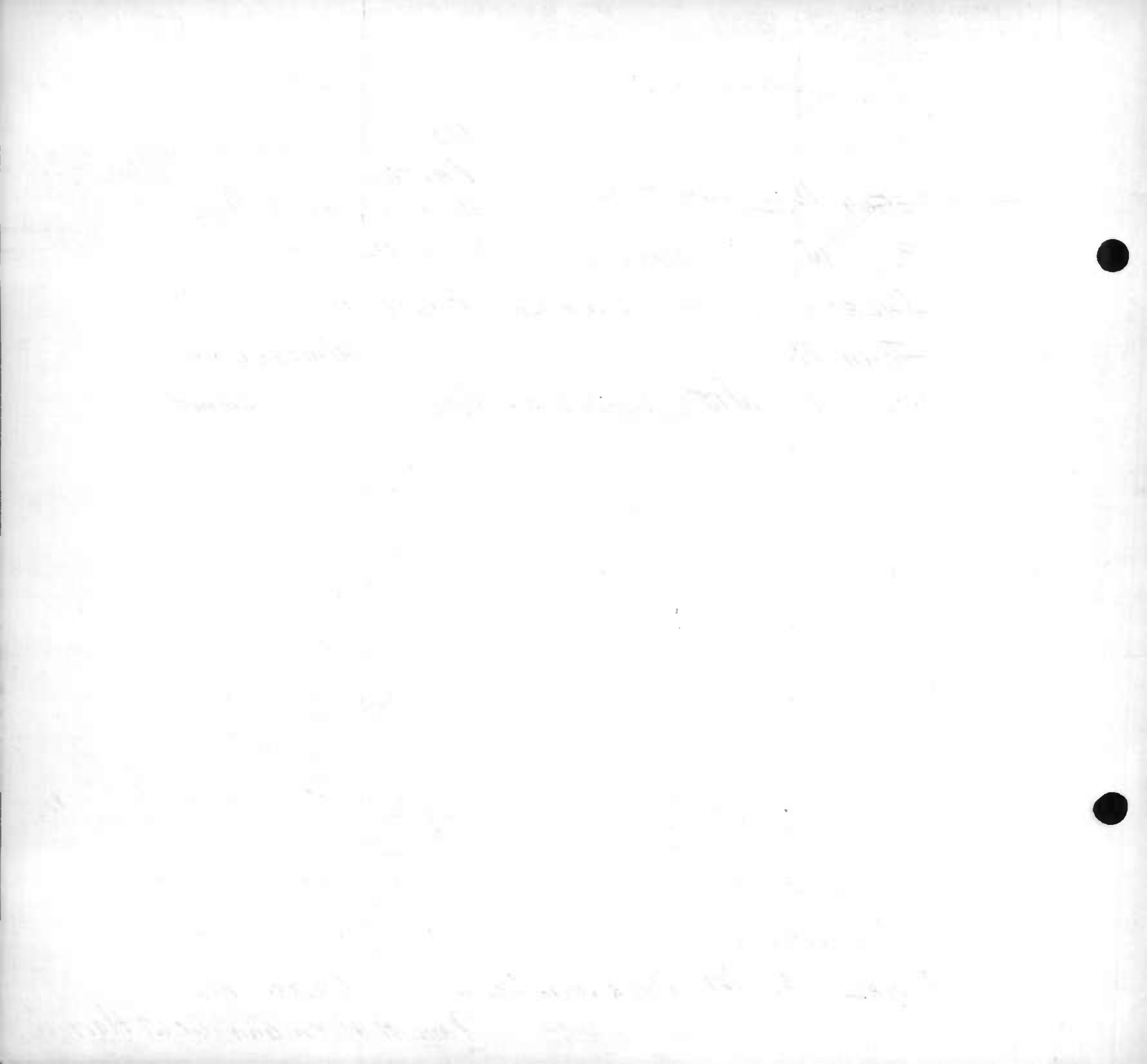
ASTHMA BRONCHITIS
 CORONARY ARTERY DISEASE
 CONGESTIVE HEART FAILURE
 MYOCARDIAL INFARCTION

FRIDTJOF RICHARDSON
 3-2-51
 3-2-51
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2517	
BIRTH NO. 67 2517		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RUDOLPH A. DREYER		2. DATE AND HOUR OF DEATH 3/8/67 7 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 27-01	
FULL NAME OF HOSPITAL OR INSTITUTION 3604 WOODLEA AVE		D. STREET ADDRESS (If rural, give location) 3604 WOODLEA AVE			
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Oct. 18. 96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY HESS SHOE CO		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
13. FATHER'S NAME JOHN. H.		14. MOTHER'S MAIDEN NAME ? WINTERLING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1st. WW		16. SOCIAL SECURITY NO. 213-28-3048A		17. INFORMANT WIFE ADDRESS SAME	
18. 2040 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Lymphatic Leukemia, chronic DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 340 -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1965 to March 8 1967 , that (I) (we) last saw the deceased alive on March 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis Krause M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) LOUIS KRAUSE		23D. ADDRESS M.D. 11 E CHASE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3/11/67	24C. NAME OF CEMETERY or CREMATORY PARKWOOD Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967	25B. NAME OF REGISTRAR Paul E. Falsky	25C. FUNERAL DIRECTOR Paul A. Heemann		ADDRESS 6067 Hartford	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2518	
M.E. CASE NO.		FREDERICK SCHRIEFER		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Frederick Schriefer</i>		2. DATE AND HOUR OF DEATH <i>3-10-67</i> <i>11:32 A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND		A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
D. STREET ADDRESS (If rural, give location) 6536 PARNELL AVENUE		E. STREET ADDRESS (If rural, give location) 6536 PARNELL AVENUE		26-36	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-27-99	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired,		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Schriefer		14. MOTHER'S MAIDEN NAME Josephine Spangenberg	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army, WW I		16. SOCIAL SECURITY NO. 213-07-4625		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Chronic Bronchitis and Emphysema</i> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>> 12 years</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-5</i> 19 <i>67</i> to <i>3-10</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2-10</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>David Mishelovich</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-10-67</i>	
23C. PHYSICIAN'S NAME (Type) Dr. David Mishelovich		23D. ADDRESS 4940 Eastern Avenue Baltimore 21224, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-1967		24C. NAME of CEMETERY or CREMATORY Belair Memorial	
24D. LOCATION (City, town, or county) (State) Belair, Maryland		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Md.		25D. ADDRESS 21222			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2519	
BIRTH NO. 67 2519		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Maurice W. Sparwasser (George)		March 10, 1967 2 15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospital		A. STATE Maryland B. COUNTY Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 53-00	
		D. STREET ADDRESS (If rural, give location) 7905 Wallace Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/23/04
		9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Sparwasser		14. MOTHER'S MAIDEN NAME Mary Susan Kenny	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-2723	
		17. INFORMANT (Wife) Dundalk, Md. 21222 Mrs. Josephine Sparwasser, 7905 Wallace Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11T-260X ACUTE MYOCARDIAL INFARCTION ARTEROSCLEROTIC HEART DISEASE		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/5 1966 to 3/10 1967, that (I) (we) last saw the deceased alive on 3/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Theodore C. Patterson		23B. DATE SIGNED 3/11/67	
23C. PHYSICIAN'S NAME (Type) Theodore C. Patterson		23D. ADDRESS 105 Main St. Dundalk, Md. 21222	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/14/67	24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967	25B. NAME OF REGISTRAR Robert E. Fairman	25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2520		Registered No. 67 2520	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Mary Schaefer		2. DATE AND HOUR OF DEATH March 11, 1967 330 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 734 S. Ellwood Ave.				A. STATE Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 734 S. Ellwood Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/5/90	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Frank Zajic			14. MOTHER'S MAIDEN NAME Julia Prokesh				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT (husband) Baltimore, Md. 21224 Charles Schaefer, 734 S. Ellwood Ave.		
18. 420,017-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus.				CAUSE OF DEATH (A) arterio sclerotic heart disease, DUE TO (B) Generalized arterio-sclerosis DUE TO (C) Diabetes Mellitus.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/15/1946 to 7/1/1967 , that (I) (we) last saw the deceased alive on 7/1/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. A. Flanagan Jr. M.D.				23B. DATE SIGNED 3/11/67		23C. PHYSICIAN'S NAME (Type) Edward A. Flanagan Jr. M.D.	
23D. ADDRESS 3501 Fait Ave. Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 3/14/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS Md. John J. Duda Inc. 2829 Hudson St. Balto.			

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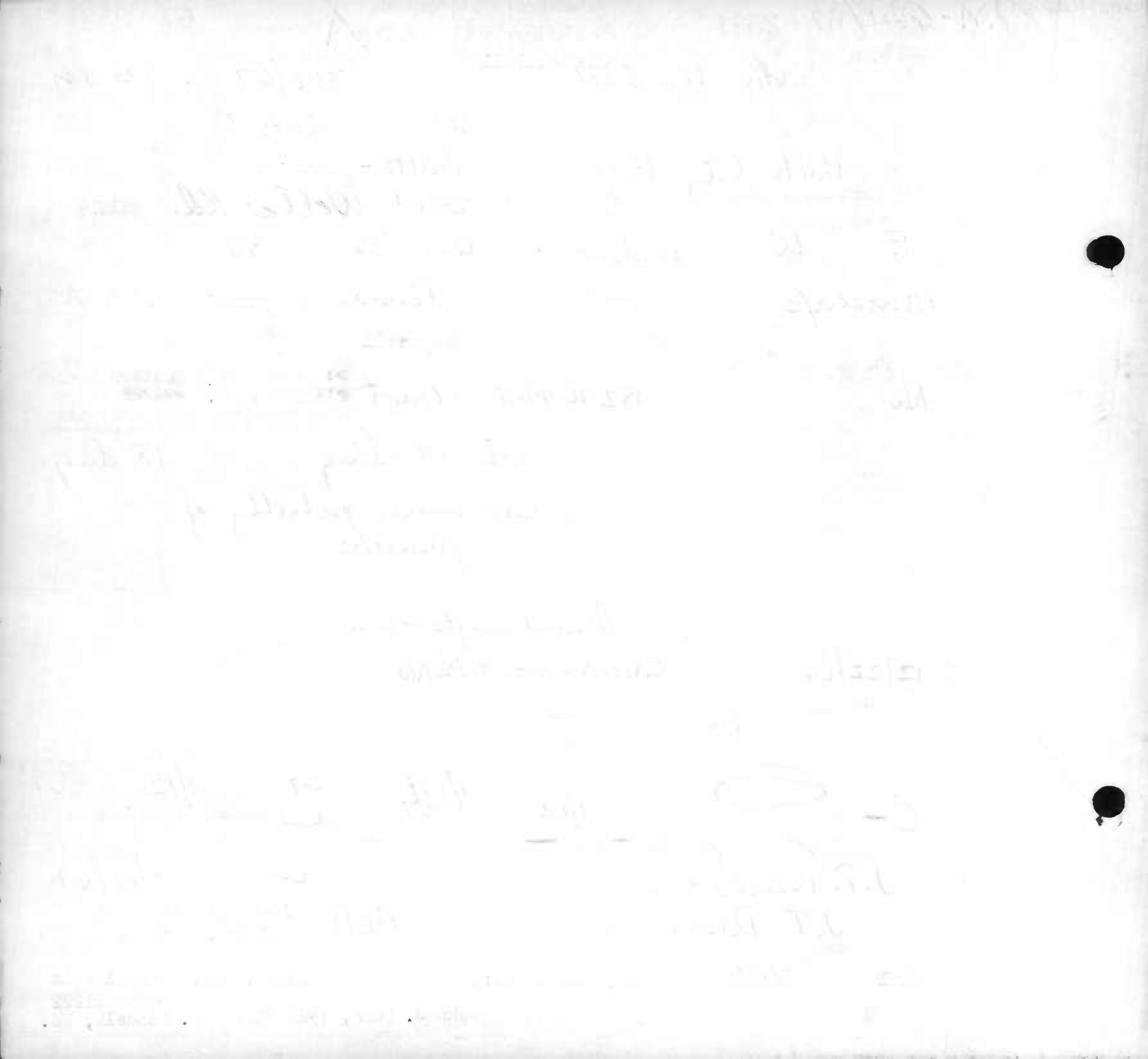
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 62467 2521		BALTIMORE CITY HEALTH DEPT.		Registered No. 67 2521	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sadie Marshall		2. DATE AND HOUR OF DEATH 3/12/67 150 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto Co		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto - Edgemere 53-00	
FULL NAME OF HDSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto City Hosp 4940 Eastern Avenue Baltimore, Maryland #21224		D. STREET ADDRESS (If rural, give location) 2919 Wells Rd. #21219		5. SEX Female 6. RACE White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow		8. DATE OF BIRTH 4-10-1866		9. AGE (In years lost birthday) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Penna. Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Lehr		14. MOTHER'S MAIDEN NAME Emma Russell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 182-16-4913		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue Baltimore, Md. #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) GI bleeding DUE TO (B) Carcinoma, probably of pancreas DUE TO (C) —		INTERVAL BETWEEN ONSET AND DEATH 18 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thrombocytopenia					
19A. DATE OF OPERATION 12/22/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer-unresectable		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/10/67 to 3/12/67 and that (1) (myself) last saw the deceased alive on 3/12/67 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.T. Davidson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/12/67	
23C. PHYSICIAN'S NAME (Type) J.T. Davidson		23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/67		24C. NAME OF CEMETERY or CREMATORY Saint Paul Cemetery	
24D. LOCATION Pine Grove, Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR John J. Duda			
ADDRESS 7922 Wise Ave. Dundalk, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2522		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2522	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Dennis Sr.		2. DATE AND HOUR OF DEATH March 11, 1967 5:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		D. STREET ADDRESS (If rural, give location) 7537 Westfield Road		53-00	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 8, 1916	9. AGE (In years lost birthday) 50	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sliter Operator		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Nicholas Dennis		14. MOTHER'S MAIDEN NAME Anna Sivulich		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army 1936		16. SOCIAL SECURITY NO. 187-03-2176		17. INFORMANT (Wife) Maryland 21222 Mrs. Marie Dennis, 7537 Westfield Rd. Dundalk	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 163X CAUSE OF DEATH (A) CARCINOMA OF LUNGS DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS		19. DATE OF OPERATION		20. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat. White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/15/66 to 10/11/66, that (I) last saw the deceased alive on 10/7/66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.		23A. SIGNATURE W. E. Baermann		23B. DATE SIGNED 3/11/67	
23C. PHYSICIAN'S NAME (Type) W. E. Baermann		23D. ADDRESS M.D. 3401 Dundalk, Ave. Dundalk, Md. 21222		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 3/15/67		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>67 2523</u>	
BIRTH NO. <u>67 2523</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CRAMBLITT, ELIZABETH MARY C.		2. DATE AND HOUR OF DEATH MARCH 11, 1967 1:50 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTO., MD. 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY <u>BALTO.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) ARBITER 21227 BALTO. 53-00 D. STREET ADDRESS (If rural, give location) BOX 2394 - DORSEY RD. - RD. 4.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 06-02-03	9. AGE (In years last birthday) 63	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME - - - - Miller DEC'D			14. MOTHER'S MAIDEN NAME MINNIE (MORRISON) King DEC'D				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES RECORDS - BALTO., MD. 21229		
18. <u>522221</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Acute pulmonary edema</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 11, 1967</u> to <u>MARCH 11, 1967</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>MARCH 11, 1967</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>S. Korbully</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/11/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. KORBULLY</u>				23D. ADDRESS <u>ST. AGNES HOSPITAL - BALTO., MD. 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21227	

10/10/50

TO: Mr. [illegible]

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

10-10-50

10/10/50

TO: (10/10/50) [illegible]

FROM: [illegible]

DATE: [illegible]

RE: [illegible]

10/10/50

10/10/50

10/10/50

10/10/50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 2524					CERTIFICATE OF DEATH					Registered No. 67 2524				
1. NAME OF DECEASED (Type or Print) <i>Billy Lewis Britt</i>					2. DATE AND HOUR OF DEATH <i>3/11/67 8:45 A.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>USPHS Hosp Wyman Pl Drive 431st St.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>3</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Cedartown V-09</i>				
D. STREET ADDRESS (If rural, give location) <i>616 Central St.</i>					5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>(W)</i>					8. DATE OF BIRTH <i>3/11/31</i> 9. AGE (In years last birthday) <i>36</i>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Ga.</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>J. L. Britt</i>					14. MOTHER'S MAIDEN NAME <i>Christine Gerham</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>					16. SOCIAL SECURITY NO. <i>25-244-8742</i>					17. INFORMANT ADDRESS <i>USPHS Hosp Records</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Malignant Lymphoma</i> DUE TO (B) _____ DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <i>months</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>2</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>Yes</i>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (1) (this hospital) attended the deceased from <i>11-26-1966</i> to <i>3-11-1967</i> , that (2) (we) last saw the deceased alive on <i>3-11-1967</i> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.									
23A. SIGNATURE <i>M.D. Bellamy</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>3-11-67</i>				
23C. PHYSICIAN'S NAME (Type) <i>M.D. Bellamy</i>					M.D. <i>PHS Hospital Baltimore, Md.</i>					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>3/15/67</i>					24C. NAME of CEMETERY or CREMATORY <i>Northview Cemetery</i>				
24D. CITY, TOWN, OR COUNTY <i>Cedartown</i>					24E. STATE <i>Ga.</i>					24F. ZIP CODE <i>XXXXXXX</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>					25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>				
25D. ADDRESS <i>4107 Wilkens Ave.</i>					25E. CITY, TOWN, OR COUNTY <i>Baltimore, Maryland</i>					25F. ZIP CODE <i>21229</i>				

Call him
at 12 o'clock

with the
paper in the

(2)

Circle 200

200

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2525		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2525	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPH MATTHEW DAYUSE		2. DATE AND HOUR OF DEATH MARCH 12, 1967 1:25 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE PENNSYLVANIA B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL LOMBARD & GREENE STS. BALTO. MD 21201		C. CITY OR TOWN (If outside city limits, write RURAL and give township) AMBRIDGE		D. STREET ADDRESS (If rural, give location) 328 12th St.	
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/12/00	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Sharon, Pa. U.S.A.	
13. FATHER'S NAME George Bayuse		14. MOTHER'S MAIDEN NAME Elizabeth Sudzina		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Pt. Record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS		CAUSE OF DEATH (A) DUE TO Septicemia (B) DUE TO Gas Gangrene, but abd. wall. (C) Peritonitis		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 3/1/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Occult GI BLEED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/1 19 67 to 3/12 19 67, that (1) (we) last saw the deceased alive on 3/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irvin M. Sopher M.D.				23B. DATE SIGNED 3/12/67	
23C. PHYSICIAN'S NAME (Type) IRVIN M. SOPHER		23D. ADDRESS University Hospital, Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-67		24C. NAME OF CEMETERY or CREMATORY Divine Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Bell Acres, Allegheny Co., Penna.		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave- 21229			

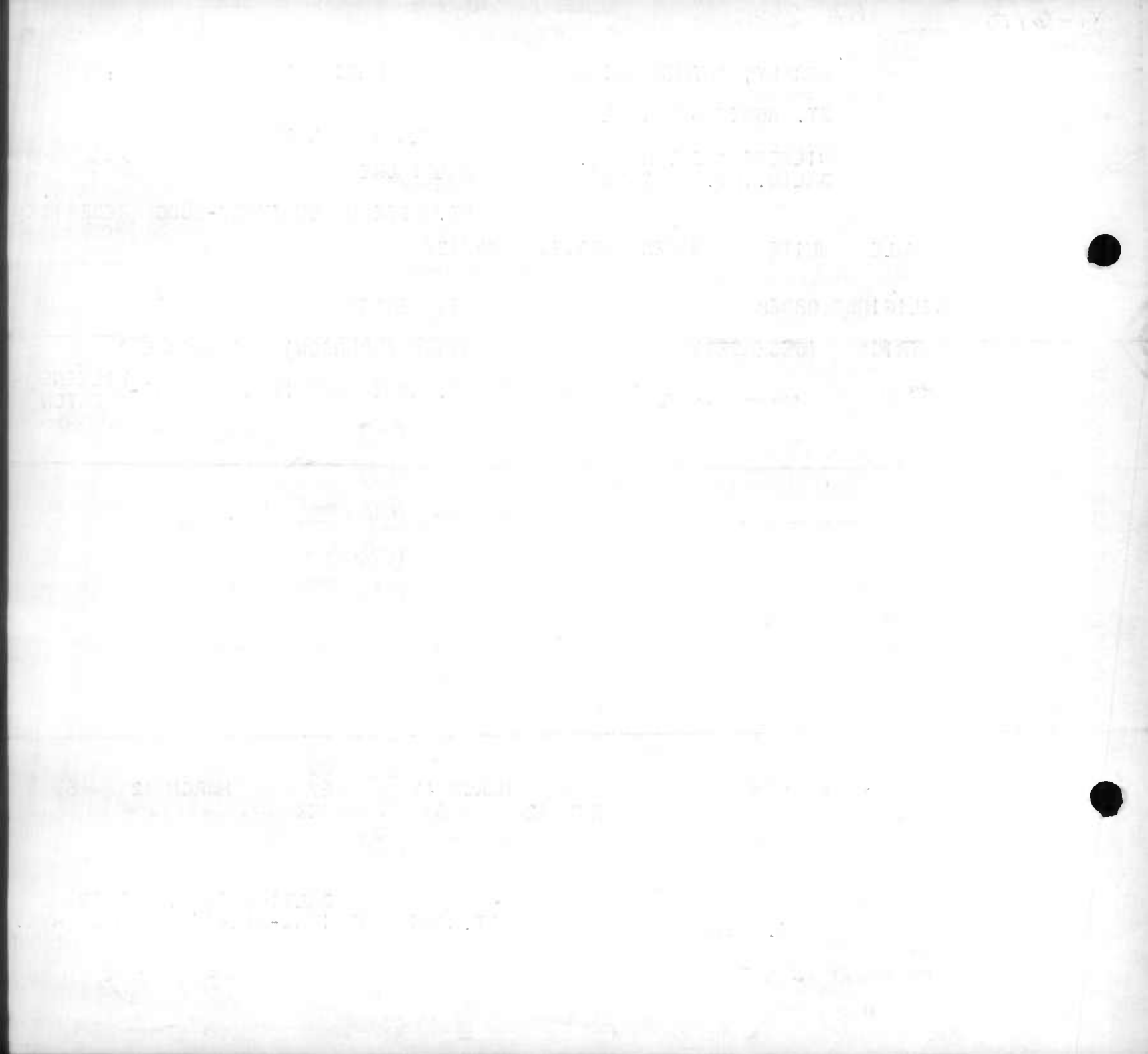
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2526				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2526	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print)				MURPHY, FATHER BRIAN		MARCH 12, 1967		6:45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
ST. AGNES HOSPITAL				A. STATE		B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND		21229			
WILKENS & CATON AVE.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE		20-08	
BALTO., MD. 21229				D. STREET ADDRESS (If rural, give location)		ST. JOSEPH MONASTERY-3800 FREDERICK AVE.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
MALE		WHITE		WIDOWED, DIVORCED (specify) NEVER MARRIED		04/12/99		67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RELIGIOUS ORDER						NEW JERSEY		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
PATRICK (DECEASED)				AGNES (JOHNSON) (DECEASED)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO YES				214 54 3863		ST. AGNES HOSPITAL RECORDS-		WILKENS & CATON	
18. 381.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Hepatic Coma					
ANTECEDENT CAUSES				(B) Esophageal Varices and GI bleeding					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Liver Cirrhosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (X) (this hospital) attended the deceased from MARCH 12 1967 to MARCH 12 1967, that (X) (we) last saw the deceased alive on MARCH 12 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
E. WEISS									
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		BALTIMORE, MD. 21229		ST. AGNES HOSPITAL-WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Removal		3-14-67				Union City, N.J.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 15 1967		Robert E. Fadden, M.D.		Barry J. Fawcett, M.D.		4400 N. Charles Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2527	
BIRTH NO. 67 2527		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Hinte, Sr.		2. DATE AND HOUR OF DEATH 9:50 PM, 3.12.67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Cecil Co.			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKTON		57-21	
		D. STREET ADDRESS (If rural, give location) 7 NORMAN ALLEN ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Jan. 29, 1899	9. AGE (In years lost birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10B. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHRIS HINTE		14. MOTHER'S MAIDEN NAME ANNIE BORN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-12-0421		17. INFORMANT 7 Norman Allen St. Mrs. Beatrice M. Hinte, Elkton, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Emphysema		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Silicosis		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3.12.67 19 to 3.12.67 19 that (I) (we) lost saw the deceased alive on 3.12.67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert M. Winslow M.D.				23B. DATE SIGNED 3/13/67	
23C. PHYSICIAN'S NAME (Type) Robert M. Winslow		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/67		24C. NAME of CEMETERY or CREMATORY Gilpin Manor Memorial Park, Elkton, Md.	
24D. LOCATION (City, town, or county) (State) Elkton, Md.		24E. LOCATION (City, town, or county) (State) Elkton, Md.		24F. LOCATION (City, town, or county) (State) Elkton, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.	

1944-1945

1944-1945

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
G-4216 67 2528					CERTIFICATE OF DEATH				
BIRTH NO.					Registered No. 67 2500				
M.E. CASE NO. 2528					1. NAME OF DECEASED (Type or Print) <i>James, Gilchrist (Edward)</i>				
2. DATE AND HOUR OF DEATH <i>3-13-67 6:50 P.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital 33</i>					A. STATE <i>MD</i> B. COUNTY				
5. SEX <i>MALE</i> 6. RACE <i>NEGRO</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 6-04</i>				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>					D. STREET ADDRESS (If rural, give location) <i>2655 120 N. Chapel St.</i>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Steel Worker</i>					8. DATE OF BIRTH <i>3-12-29-29</i> 9. AGE (In years last birthday) <i>77</i>				
10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Prince George's Co. Md.</i>				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <i>EDWIN Gilchrist</i>				
14. MOTHER'S MAIDEN NAME <i>JENNIE Young</i>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				
16. SOCIAL SECURITY NO. <i>216-10-3944</i>					17. INFORMANT <i>James H. Gilchrist</i> ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) <i>Pneumonia</i> DUE TO				
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)					(B) DUE TO				
					(C) DUE TO				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CHF, Chronic Lung Disease</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <i>No</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>3-12-1967</i> to <i>3-13-1967</i> , that (I) (we) last saw the deceased alive on <i>3-13-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>R. Moses</i>					23B. DATE SIGNED <i>3-13-67</i>				
23C. PHYSICIAN'S NAME (Type) <i>Robb Moses</i>					23D. ADDRESS <i>JHH</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>					24B. DATE <i>Mar 17/67</i>				
24C. NAME OF CEMETERY OR CREMATORY <i>W. Calvary Cem</i>					24D. LOCATION (City, town, or county) (State) <i>A.A. County</i>				
25A. DATE RECEIVED BY HEALTH DEPT. <i>MAR 18 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>				
25C. FUNERAL DIRECTOR <i>Joseph T. Erickson</i>					25D. ADDRESS <i>1129 N. Calhoun</i>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2529		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2529	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) KATHLEEN A. PARROTT			2. DATE AND HOUR OF DEATH 3/13/67 3³⁰ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 Rosewood State Hospital D. STREET ADDRESS (If rural, give location)		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6/5/51	9. AGE (In years last birthday) 15	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN PARROTT			14. MOTHER'S MAIDEN NAME ANN E. LAWRENCE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	17. INFORMANT ADDRESS ANN E. PARROTT - 4308-JOPLIN DR ROCKVILLE, MD.		
18. 490X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pericarditis Pneumonia			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mongolism					
19A. DATE OF OPERATION 2 —		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/1 1967 to 3/13 1967 , that (I) (we) lost saw the deceased alive on 3/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Salmon S. Agus M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/13/67	
23C. PHYSICIAN'S NAME (Type) ZALMAN S. AGUS M.D.				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3/14/67	24C. NAME of CEMETERY or CREMATORY FORT LINCOLN CREMATORY		24D. LOCATION (City, town, or county) (State) COLMAR MAR, FORT COLE, MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS W. W. CHAMBERS, Inc, SILVER SPRING, MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2530		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2530	
M.E. CASE NO.		CERTIFICATE OF DEATH		P	
1. NAME OF DECEASED (Type or Print) Ermatinger, Frances Kathleen		2. DATE AND HOUR OF DEATH 3/9/67		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore City			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		53-00	
		D. STREET ADDRESS (If rural, give location) 323 Holly Hill Rd. Reisterstown, Md.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NM	8. DATE OF BIRTH 12/16/59	9. AGE (In years lost birthday) 7	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Columbus, Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William C Ermatinger		14. MOTHER'S MAIDEN NAME Susan Gerlach	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [redacted]		17. INFORMANT Wm C Ermatinger	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Shock Intra Cerebral hemorrhage. 5 days.		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Pneumonia, Sepsis, and fracture of femur 5 days.		20. INTERVAL BETWEEN ONSET AND DEATH 5 days.	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. DATE OF OPERATION 3/4/67		23. CONDITION FOR WHICH OPERATION WAS PERFORMED [redacted]	
24. DATE OF OPERATION 3/4/67		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
33. I certify that (I) (this hospital) attended the deceased from 3/4 1967 to 3/9 1967, that (I) (we) last saw the deceased alive on 3/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		34. SIGNATURE [Signature] M.D.		35. DATE SIGNED 3/10/67	
36. PHYSICIAN'S NAME (Type) Arnold Brenner		37. ADDRESS SINAI Hosp.			
38. BURIAL CREMATION, REMOVAL (Specify) Burial		39. DATE 3/14/67		40. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
41. LOCATION (City, town, or county) Baltimore, Md.		42. DATE REC'D BY HEALTH DEPT. MAR 15 1967		43. NAME OF REGISTRAR R. E. Talbot	
44. FUNERAL DIRECTOR H. J. Selhardt		45. ADDRESS Owings Mills, Md.			

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W-325

67 2531

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2531

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROY WATKINS

2. DATE AND HOUR PRONOUNCED DEAD

3-5-67

4:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6524 Fait Avenue 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, (DIVORCED) (Specify)

Separated

8. DATE OF BIRTH

3-16-11

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Former

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

216039317

17. INFORMANT

Wilma Alleen Ramirez 1611 Cheseco Ave.

ADDRESS

18. E916.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Carbon monoxide poisoning - associated

RXXXX

with smoke and soot inhalation -
incidental to conflagration

(B) DUE TO

(C)

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

6524 Fait Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 5 '67 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Burned in house fire

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-8-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-15-67

23C. NAME OF CEMETERY or CREMATORY

Baltimore Veterans Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Philip F. Crach 1211 Cheseco Ave.

ADDRESS

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2532		CERTIFICATE OF DEATH		67 2532	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mr. Edward G. Mueller			2. DATE AND HOUR OF DEATH 3-12-67, 10 ⁰⁰ a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.			A. STATE MD. B. COUNTY BALTIMORE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 2 Glenwood Rd. #21		
5. SEX MALE	6. RACE WHITE	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-15-07	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY SHERIFF, BALTO. CO.		11. BIRTHPLACE (State or foreign country) Baltimore, MD.	
13. FATHER'S NAME Henry J. Mueller			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			14. MOTHER'S MAIDEN NAME BARBARA A. Becker		
16. SOCIAL SECURITY NO. 213-09-4126		17. INFORMANT ADDRESS HELEN E. MUELLER 2 GLENWOOD RD, BALTO, 21221, MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Uremia (B) Generalized ASCVD (C) Diabetes Mellitus		
19. DATE OF OPERATION			20. AUTOPSY? (Yes or No)		
21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		
23. SIGNATURE Octavio A. Ruiz M.D. Attending Phys. Med. Director Staff Phys. 3/12/67			24. DATE SIGNED		
25. DATE REC'D BY HEALTH DEPT. MAR 15 1967			26. NAME OF REGISTRAR Robert E. Farkas		
27. NAME OF FUNERAL DIRECTOR Charles J. Sullivan			28. ADDRESS 6224 EASTERN AVE. BALTO., 21224, MD.		

General Service Unit

11th & BALTIMORE

General Service Unit

2 Glenwood Rd. N.Y.C.

11-15-07

WHITE MARRIED

Baltimore, Md.

RETIRED

BARBARA A. [unclear]

Henry T. [unclear]

313-01-4102 HENRY T. HENRY BALTIMORE, MD.

NO

11-15-07

BURIAL 3-12-62 SACRED HEART CH.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2533	
BIRTH NO. 67 2533		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Robert Wacker</i>		2. DATE AND HOUR OF DEATH <i>3/11/67</i> <i>4 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00636 Wyeth St.</i>		A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>21-02</i> D. STREET ADDRESS (If rural, give location) <i>636 Wyeth St.</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>2/18/1881</i>	9. AGE (In years lost birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Floor Covering</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-0543774</i>		17. INFORMANT <i>Mrs Margaret L. Parrish</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO <i>Carcinoma Splenic flexa sigmoid Colon</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-22</i> 19 <i>48</i> to <i>3/11</i> 19 <i>67</i> , that (I) was last saw the deceased alive on <i>3/10</i> 19 <i>67</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.					
23A. SIGNATURE <i>John P. Urlock Jr</i> M.D.				23B. DATE SIGNED <i>3/13/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR</i>		23D. ADDRESS <i>1227 Washington Blvd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/14/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Western Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1967</i>			
25B. NAME OF REGISTRAR <i>R. B. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John J. Conantson Inc</i>			
25D. ADDRESS <i>01 St 23, Md.</i>					

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2534				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2534	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				CARTER, EARL VAN DORN		MARCH 11, 1967 7:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
VETERANS ADMINISTRATION HOSPITAL				MARYLAND BALTIMORE			
3900 LOCH RAVEN BOULEVARD				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALTIMORE, MARYLAND 21218				BALTIMORE 9-09			
D. STREET ADDRESS (If rural, give location)				1000 EAST HOFFMAN STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?		
MALE	CAUCASIAN	WIDOWED, DIVORCED (specify) DIVORCED	11-2-89	78	UNITED STATES		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MERCHANT MARINE				BALTIMORE, MD.		UNITED STATES	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HENRY CARTER				MARY L. LOUELLAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES 11/6/17-11/27/18		218-07-12-21		VETERANS HOSPITAL RECORDS		3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CARCINOMA OF LUNG, BRONCHOGENIC			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CARCINOMA of Lung			
				PULMONARY CONGESTION, SEVERE, BILATERAL			
				(B) DUE TO			
				PORTAL CIRRHOSIS, LIVER			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 20 19 66 to MARCH 11 19 67, that (X) (we) last saw the deceased alive on MARCH 11 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Robert R. Kent M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						March 12, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ROBERT R. KENT, M.D.				VETERANS ADMINISTRATION HOSPITAL			
				3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/14/67		Baltimore National		Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 15 1967		Robert E. Johnson		William E. Johnson		8521 Loch Raven B'VD.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2535		REGISTERED NO. 67 2535	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>Paul P. Zilka (Paul P. Zilka)</u>				2. DATE AND HOUR OF DEATH <u>Mar. 16 1967</u> <u>3:43 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Baltimore General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>2504</u> D. STREET ADDRESS (If rural, give location) <u>710 Pontiac Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>7-29-93</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min:	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Little Falls, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Zilka</u>			14. MOTHER'S MAIDEN NAME <u>Veronica Picharski</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>215-10-9059</u>		17. INFORMANT <u>Mrs. Virginia Zilka- (same)</u>			
18. <u>420.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION, ACUTE</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>SEVERAL YEARS</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10:30-11-1967</u> to <u>3:43 PM 3-11-1967</u> , that (I) (we) last saw the deceased alive on <u>3-11-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <u>Harold A. Burham</u> M.D.				23B. DATE SIGNED <u>3-11-67</u>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-15-1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George J. Gonce-4001 Ritchie Hgwy., Baltimore</u>			

May 10, 1944

Wash. D.C.

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Wash. D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2536		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2536	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) THELMA R. PLUM PLUM MISS THELMA		2. DATE AND HOUR OF DEATH B. 12. 1967 3.55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2-02			
		D. STREET ADDRESS (If rural, give location) 402 S. REGISTER ST. (31)			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 12. 22. 1909	9. AGE (In years last birthday) 57	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Decorator Supvr.		10B. KIND OF BUSINESS OR INDUSTRY Ice Cream		11. BIRTHPLACE (State or foreign country) MD. Maryland	
13. FATHER'S NAME ANDREW PLUM		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 212-09-3889		17. INFORMANT Anna P. Schroll, 402 S. Register St CHURCH HOME & HOSP.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) cerebrovascular accident one week (B) Pneumonia (C) A.S.C.U.D.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3. 6. 1967 to 3. 12. 1967, that (I) (we) last saw the deceased alive on 3. 12. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Idilia Mariant		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-12-67	
23C. PHYSICIAN'S NAME (Type) IDILIA C MARIANO		23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/67		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, State or County) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE	


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH						Registered No. <u>67 2537</u>					
BIRTH NO. <u>67 2537</u>						M.E. CASE NO. <u>13</u>					
1. NAME OF DECEASED (Type or Print) <u>Strouth, Maggie Ethel</u>						2. DATE AND HOUR OF DEATH <u>2. 25 Am. Mar. 12. 1967</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u>						A. STATE <u>md</u> B. COUNTY <u>Balt Co</u>					
(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Parkton 53-00</u>					
D. STREET ADDRESS (If rural, give location) <u>York Rd.</u>											
5. SEX <u>F</u>		6. RACE <u>white</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>		8. DATE OF BIRTH <u>01-31-03</u>		9. AGE (In years lost birthday) <u>64</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Elizabethton Tenn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Dave Clemens</u>						14. MOTHER'S MAIDEN NAME <u>Lilly Taylore</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>John W. Strouth, York Rd., Parkton, Md.</u>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>331 X I</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH (A) <u>CVA</u> DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) <u>—</u> DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						(C) <u>—</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>2:55 pm. Mar. 11. 1967</u> to <u>2:25 Am. Mar. 12. 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>2:25 Am. Mar. 12. 1967</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.											
23A. SIGNATURE <u>Song Won Song</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>March 12. 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR SONG WON SONG</u>						23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial & Removal</u>		24B. DATE <u>March 15 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glenwood Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Bristol, Tenn.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1967</u>				25B. NAME OF REGISTRAR <u>John E. Taylor</u>				25C. FUNERAL DIRECTOR <u>Paul Hartenstein, New Freedom, Pa.</u>			
						ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2538		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2538	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LUSBY, CHARLES ROMAN		2. DATE AND HOUR OF DEATH 3-12-67 10:40PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 21229 C. STREET ADDRESS (If rural, give location) 730 Brookwood Rd.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-29-86	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Partner		10B. KIND OF BUSINESS OR INDUSTRY R.C. Heller Mattress Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES			
14. MOTHER'S MAIDEN NAME IDA M MORGAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 216-03-4822		17. INFORMANT ST. AGNES RECORDS-CATON & WILKENS AVE. Mrs. Irma V. Lusby-730 Brookwood Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) arteriosclerosis (v) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 12 19 67 to MARCH 12 19 67 , that (I) (we) last saw the deceased alive on MARCH 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3/12/67	
23C. PHYSICIAN'S NAME (Type) JOHN C POUND		23D. ADDRESS M.D. 3325 FREDERICK AVE. BALTO. MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-67		24C. NAME of CEMETERY or CREMATORY Baltimore Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Av.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. 67 2539						
BIRTH NO. 326 67 2539											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) WHITTAKER, PHILLIP SHELBOURNE					2. DATE AND HOUR OF DEATH 3-13-67 10:20A M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL					A. STATE MARYLAND B. COUNTY Baltimore 53-00						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE						
					D. STREET ADDRESS (If not give location) 1013 S-RIDGE RD. 21228						
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-20-98		9. AGE (In years lost birthday) 68			
								If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY A T & T			11. BIRTHPLACE (State or foreign country) VA.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME THOMAS Whittaker					14. MOTHER'S MAIDEN NAME ELIZABETH GRIMES						
					Mrs. Phillip Whittaker 1013 Southridge Rd. CATON AVE., BALTO., MD.						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 190 09 2605					17. INFORMANT ST AGNES HOSPITAL RECORDS, 1000 S.	
18. 199.21 CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) Metastatic carcinoma (Primary unknown.)						
ANTECEDENT CAUSES					(B) Brain metastasis						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 3-3-19 67 to 3-13-19 67, that (I) (we) last saw the deceased alive on 3-13-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. Korbuly					23B. DATE SIGNED 3/13/67						
23C. PHYSICIAN'S NAME (Type) J. KORBULY					23D. ADDRESS ST. AGNES HOSPITAL - CATON & WILKENS 21229						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-67		24C. NAME of CEMETERY or CREMATORY Lakewood Cem.		24D. LOCATION (City, town, or county) (State) Bowling Green, Va.					
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR R. E. F. J. J.		25C. FUNERAL DIRECTOR Witzke F.D.		ADDRESS 4101 Edmondson Ave.					

AGE: 01

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WHITMAN, WILLIAM STEPHEN

WILLIAM

STEVENSON

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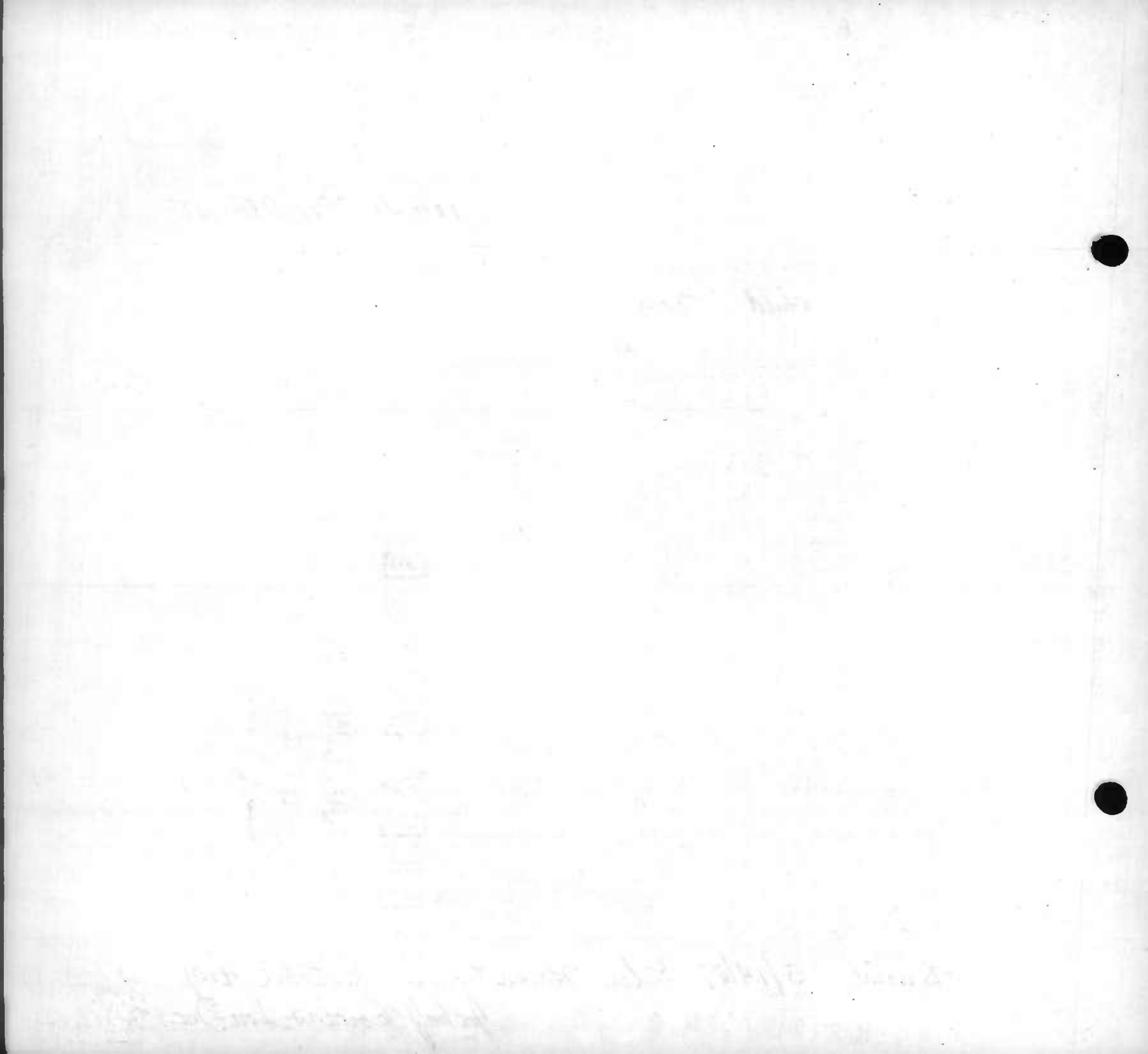
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2540</u>	
BIRTH NO. <u>67 2540</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby Boy Fell</u>		2. DATE AND HOUR OF DEATH <u>3/13/67</u> <u>1:05</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		Died <u>1'15" after birth @ Univ. Hosp.</u>		<u>Baltimore Md. 18-03</u>	
D. STREET ADDRESS (If rural, give location) <u>104 So. Poppleton St.</u>		5. SEX <u>Male</u>		6. RACE <u>White</u>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>3/12/67 11:50 PM</u>		9. AGE (In years last birthday) <u>1</u> <u>15</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Fell Jr.</u>		14. MOTHER'S MAIDEN NAME <u>JoAnn Buchman</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JoAnn Fell</u>	
ADDRESS <u>alone</u>		18. <u>73-9-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Failure of Spont. Respiration</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Congenital Thoracic Anomaly, 1hr 15"</u>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2 None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/12/67 11:50 PM</u> to <u>3/13/67 1:15 AM</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/13/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John C. Hiseley</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>John C. Hiseley</u>		23D. ADDRESS <u>University Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/14/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Eden Haven Cem.</u>	
24D. LOCATION <u>Ritchie Hwy</u>		(City, town, or county)		(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR <u>John E. Taylor</u>	
ADDRESS <u>23, Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

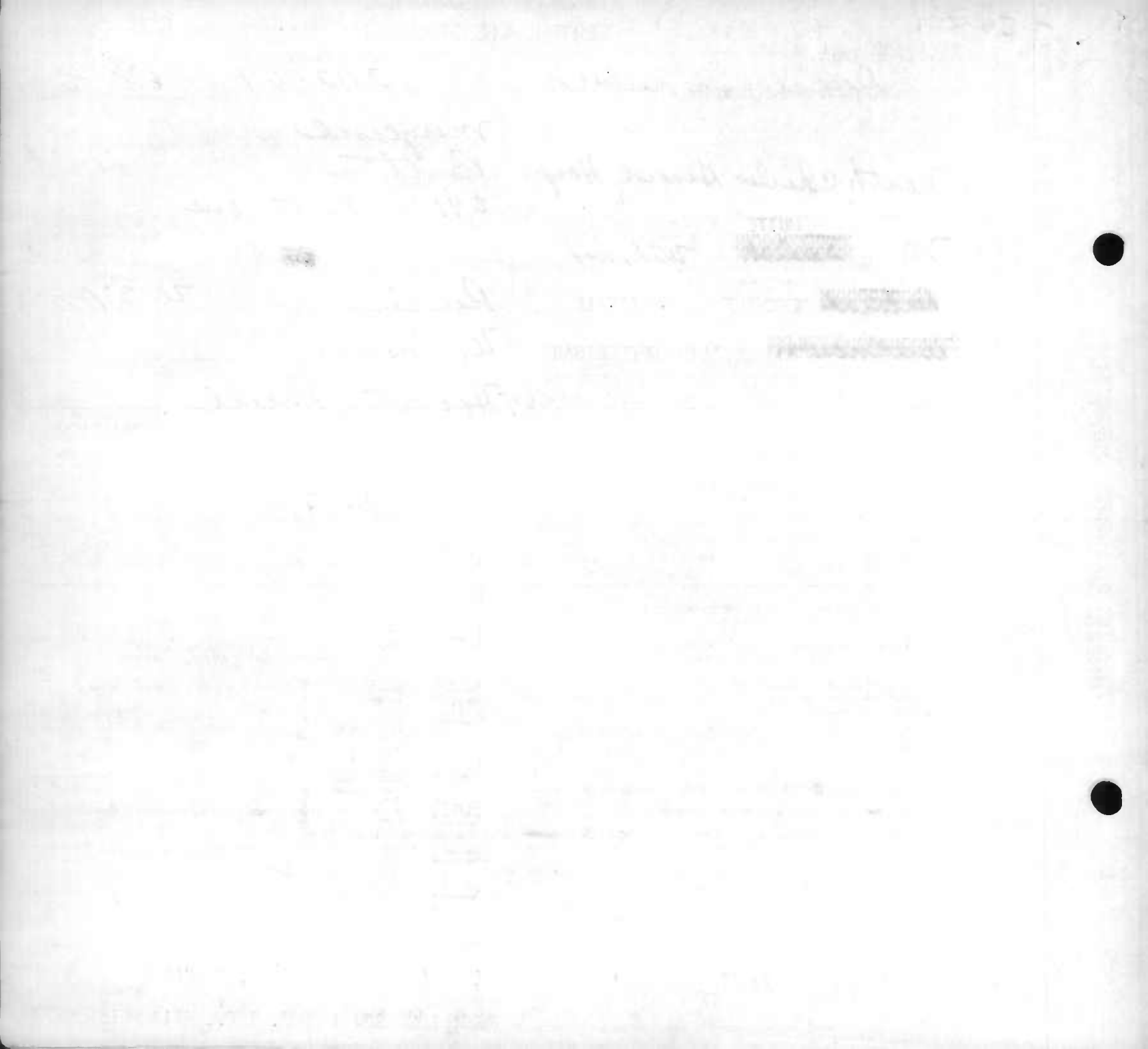
BIRTH NO. 67 2541		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2541	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DORA WOLF		2. DATE AND HOUR OF DEATH 3-10-67 10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSP.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 5341 NELSON AVE	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 1/23/93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMEN		10B. KIND OF BUSINESS OR INDUSTRY MILITARY		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROSEBERG PERSNER		14. MOTHER'S MAIDEN NAME —	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 240-09-3679		17. INFORMANT HOSPITAL CHART	
18. 465X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) RECURRENT PULM. EMBOLI		(A) DUE TO		5 WKS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CONGESTIVE HEART FAILURE; POSSIBLE DIGITOXICITY ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (If (this hospital) attended the deceased from 2-3 19 67 to 3-10 19 67 , that (I) (we) last saw the deceased alive on 3-10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin Schachter		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-10-67	
23C. PHYSICIAN'S NAME (Type) ALVIN SCHACHTER		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/13/67		24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE RECEIVED BY HEALTH DEPT. MAR 10 1967			
25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR BDL REVINSON & BROS. INC., 6010 REIST., RD.			

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

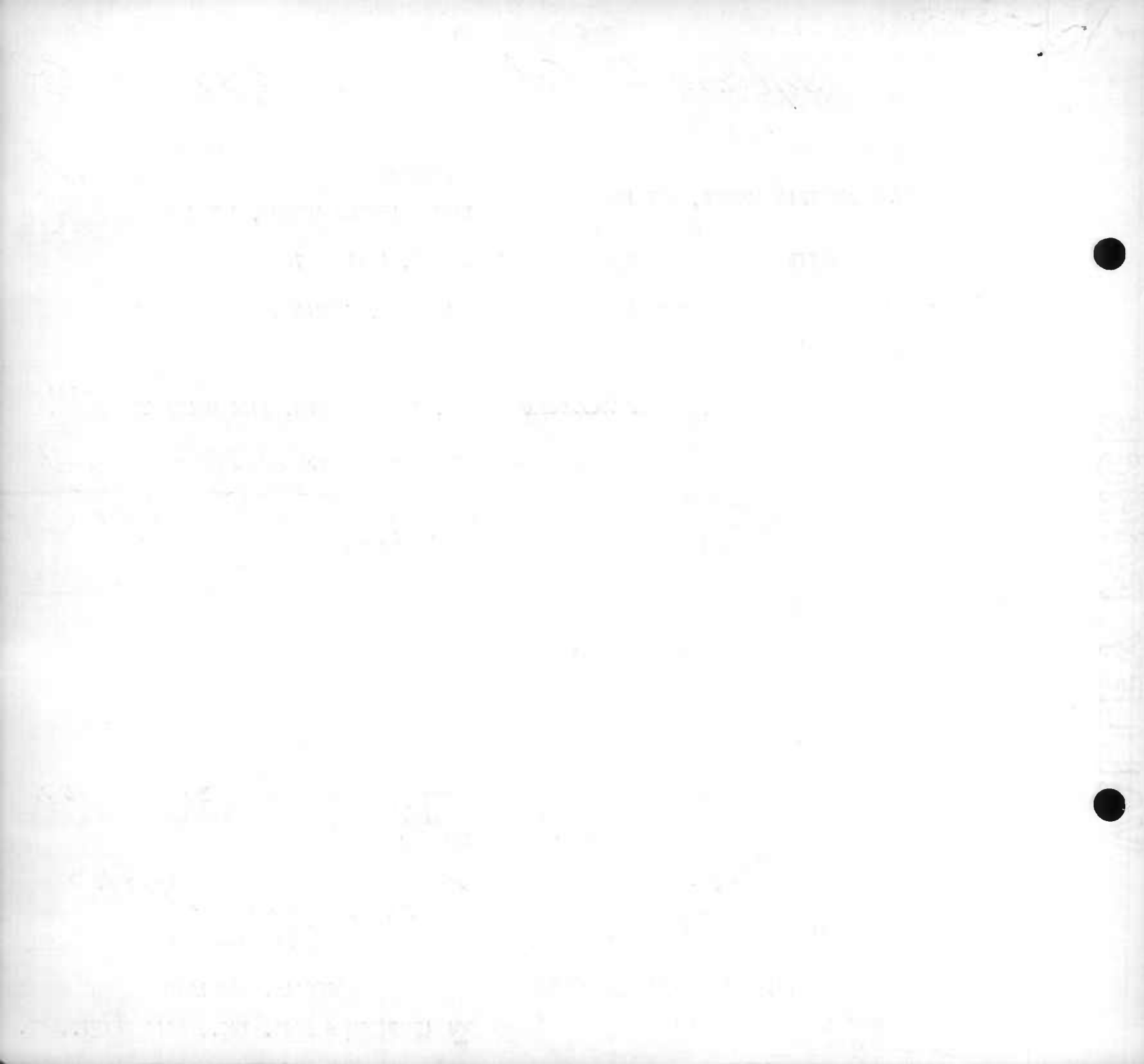
Baltimore City Health Department				Registered No. 67 2542	
BIRTH NO. 67 2542		CERTIFICATE OF DEATH		Registered No. 67 2542	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Deckerbaum Albert		2. DATE AND HOUR OF DEATH 3-12-67 6:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 North Charles General Hosp.		A. STATE Maryland		B. COUNTY Baltimore	
5. SEX M.		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH		9. AGE (In years last birthday) 84		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME BENJAMIN DECKELBAUM		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-6647		17. INFORMANT Hospital Record	
18. 443X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO Coronary artery accident, coronary			
ANTECEDENT CAUSES		(B) DUE TO HASCVD		YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3-10-67 to 3-12-67, that (I) last saw the deceased alive on 3-12-67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (see) (did) (do not) view the body after death.					
23A. SIGNATURE Albert Defore		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-12-67	
23C. PHYSICIAN'S NAME (Type) ANGELITA TOPALIN		23D. ADDRESS HCBH			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/13/67		24C. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL KOLK WOLYN	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS 602 LEVINSON & BROS. INC., 6010 REISTERSTOWN	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2543		CERTIFICATE OF DEATH		67 2543	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Sylvan G. Cohen</i>		2. DATE AND HOUR OF DEATH <i>Mar. 12/67 3:35 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>	
3400 DOLFIELD AVENUE, APT 104				B. COUNTY <i>BALTIMORE</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
				D. STREET ADDRESS (If rural, give location) <i>3400 DOLFIELD AVENUE, APT 104</i>	
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>JANUARY 8, 1897</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>RETAIL</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>MRS. JENNIE COHEN, 3400 DOLFIELD AVENUE, APT. 104</i>	
18. <i>420.1 I</i>		CAUSE OF DEATH		ADDRESS <i>3400 DOLFIELD AVENUE, APT. 104</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) <i>Acute myocardial Infart</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>ASCVD</i>			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/12</i> 19 <i>67</i> to <i>3/11</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. J. Ellen</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/13/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. J. Ellen</i>		23D. ADDRESS <i>8629 Liberty Rd. Randallstown, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3/13/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>MARYLAND LODGE</i>	
24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2544</u>	
BIRTH NO. <u>67 2544</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>PASQUALE DELLA ROSE</u>		2. DATE AND HOUR OF DEATH <u>3/14/67</u> <u>3:35 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 Md General Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Balt</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balt</u> <u>7-02</u>		
			D. STREET ADDRESS (If rural, give location) <u>832 Lugene Ave.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>9/14/90</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sparrows Point</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Anthony Nicholas Dellabore</u>			14. MOTHER'S MAIDEN NAME <u>Anna Manzetti</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2137-07-2617</u>	17. INFORMANT <u>daughter via chart</u>		ADDRESS
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>thrombosis</u> DUE TO <u>LMCA thrombosis</u> (B) <u>Generalized arteriosclerosis</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/28 1967</u> to <u>3/14 1967</u> , that (I) (we) last saw the deceased alive on <u>3/13 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald Leher</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>3/14/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ronald Leher</u>		23D. ADDRESS M.D. <u>827 Linden Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3/17/67</u>	24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2545				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2545	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MR. RAYMOND HASSELHOFF		2. DATE AND HOUR OF DEATH MAR. 13, 1967		10:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 4711 DUNCREST AVENUE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND		D. STREET ADDRESS (If rural, give location) 21206	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL				5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CITY OF BALTO. BUREAU OF SEWERS (FOREMAN)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD HASSELHOFF				14. MOTHER'S MAIDEN NAME LENA SCHMIDT		17. INFORMANT (nee Pearce) Dorothy Hasselhoff, wife, above			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII				16. SOCIAL SECURITY NO. 220-05-9287		ADDRESS			
18. 5410 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Bleeding Stomach Ulcer DUE TO (B) Septicemia DUE TO (C) Generalized Peritonitis				INTERVAL BETWEEN ONSET AND DEATH 6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 1-29-67; 2-1-67; 2-2-67; 2-15-67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Stomach Ulcer, Duodenal Stump Bleeding, Intestinal Obstruction		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-29 1967 to 3-13 1967 , that (I) (we) last saw the deceased alive on 3-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Don G. Ortiz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-13-67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 3231 Brenns Lane #13			

Black, thin, thin
specimen
characteristic features

Small, dark, irregular, irregular

For 200

1.25

1.0

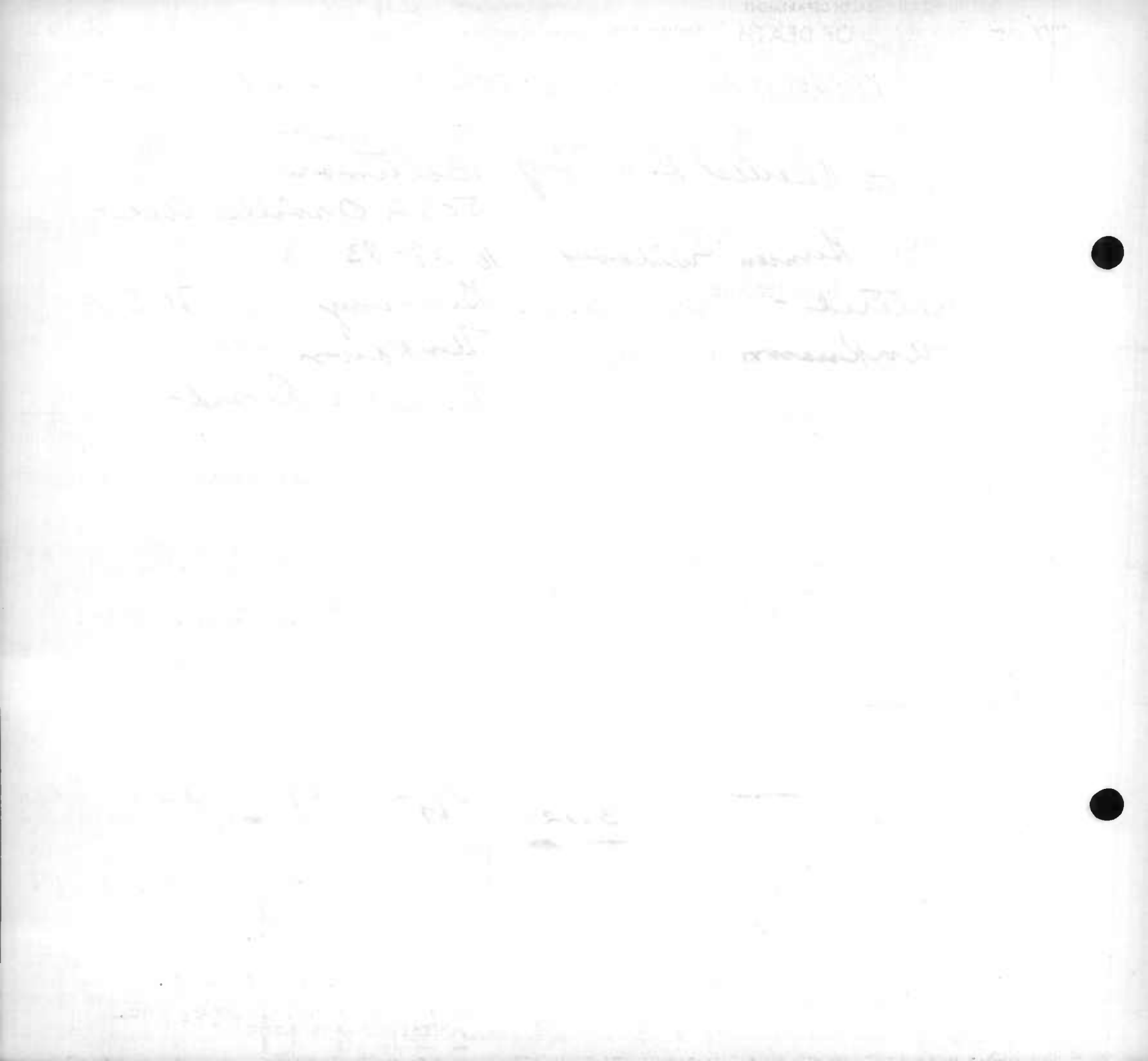
1.0

3-12-61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
67 2546					CERTIFICATE OF DEATH					Registered No. 67 2546									
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>Frederick Schwalbach Sr</i>					2. DATE AND HOUR OF DEATH <i>3-12-67 11:15 P.M. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>North Charles Gen. Hosp.</i>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>									
D. STREET ADDRESS (If rural, give location) <i>5032 Orville Ave.</i>										26-03									
5. SEX <i>M.</i>		6. RACE <i>German</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>10-28-83</i>		9. AGE (In years lost birthday) <i>83</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Cabinetmaker</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Statmore Co. Inc.</i>					11. BIRTHPLACE (State or foreign country) <i>Germany</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME XXXXXXXXXXXX <i>John Schwalbach</i>										14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX <i>Gertrude Denise</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS <i>Hospital Record-</i>									
18. <i>426.01-204.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Heart Disease</i>										CAUSE OF DEATH (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) DUE TO									
(C) DUE TO																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										<i>Chronic Lymphatic Leukemia 64's</i>									
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>3-12-1967</i> to <i>3-12-1967</i> , that (I) (we) last saw the deceased alive on <i>3-12-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>Dean Hardy</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>3-12-67</i>				
23C. PHYSICIAN'S NAME (Type) <i>Dean Hardy</i>										23D. ADDRESS <i>5002 Frankford Ave Baltimore Md.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>3/15/67</i>					24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Wilkes Barre, Pa.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>					25C. FUNERAL DIRECTOR ADDRESS <i>Schimunek Funeral Home, Inc. 3331 Brehms Lane</i>									



67 2547

CERTIFICATE OF DEATH

Registered No.

67 2547

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Mary
Margaret M Foly

2. DATE AND HOUR OF DEATH

10 March 1967

7:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

5621 Knell Ave 21206

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3-4-08
4 March 19089. AGE (In years
lost birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore
Maryland12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANK ERLINE or Erlie

14. MOTHER'S MAIDEN NAME

EVERETT WATSON

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-24-1921

17. INFORMANT

BCH: RECORDS

ADDRESS

4940 EASTERN AVENUE

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Metastases of Tumor to Brain
DUE TO(B) Bronchogenic Carcinoma
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

2 years 8 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypothyroidism

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 2 March 1967 to 10 March 1967,
that (I) ~~was~~ lost saw the deceased alive on 10 March 1967 and that in (my) ~~own~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~was~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

Alan J. Barnes

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

10 March 1967

23C. PHYSICIAN'S
NAME (Type)

DR. ALAN J. BARNES

M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE BALTO.MD. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/14/67

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 15 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

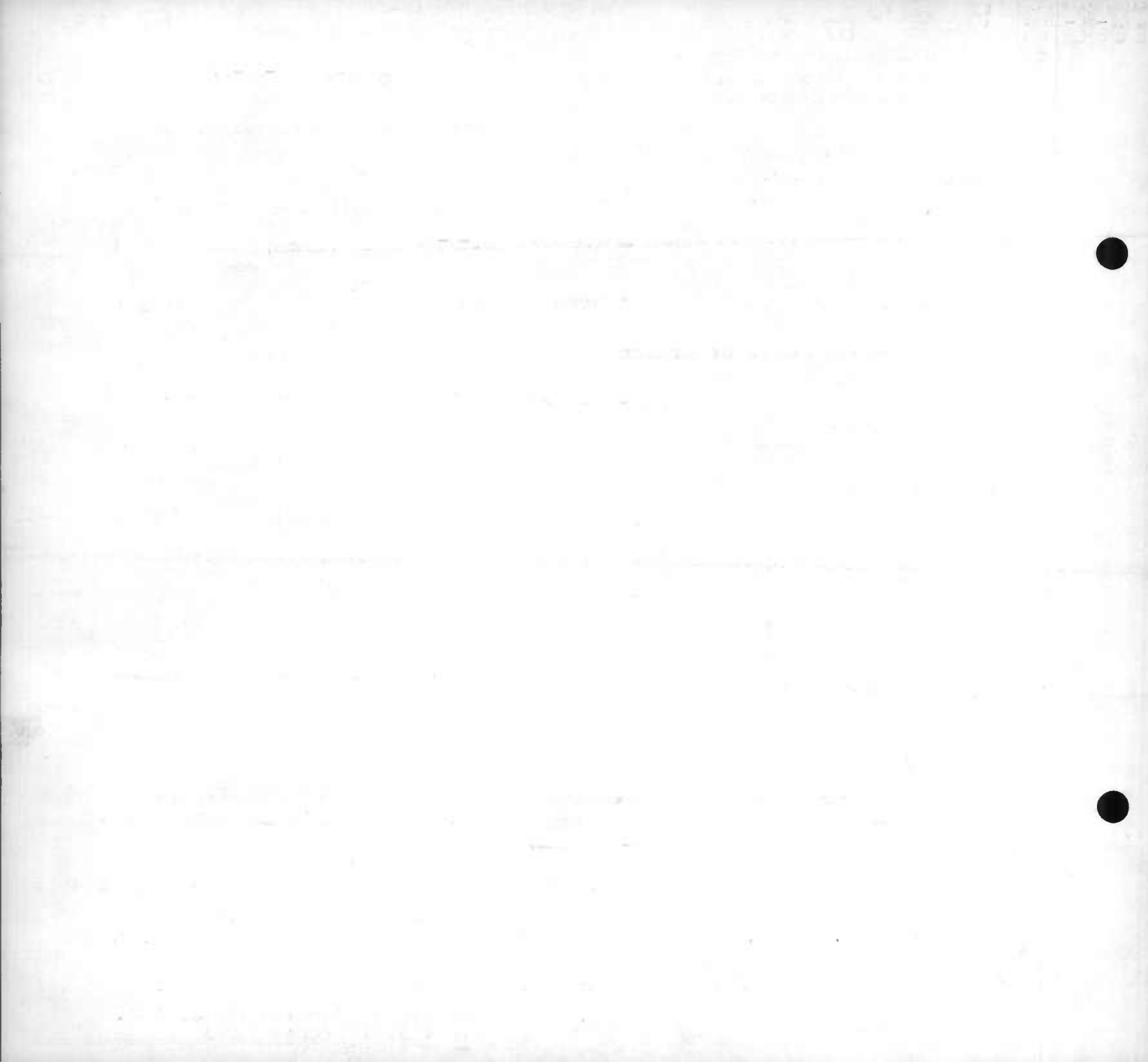
Schimunek Funeral Home, Inc.

ADDRESS

53331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO.

67 2548

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2548

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANTON

PICKA

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1967

9:55 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4306 Southern Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

10/4/1888

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR INDUSTRY

Haas Tailoring

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Picka

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-09-2905

17. INFORMANT

ADDRESS

Marie Picka, (nee Radek) wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/14/67

23C. NAME of CEMETERY or CREMATORY

Bohemian Nat. Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

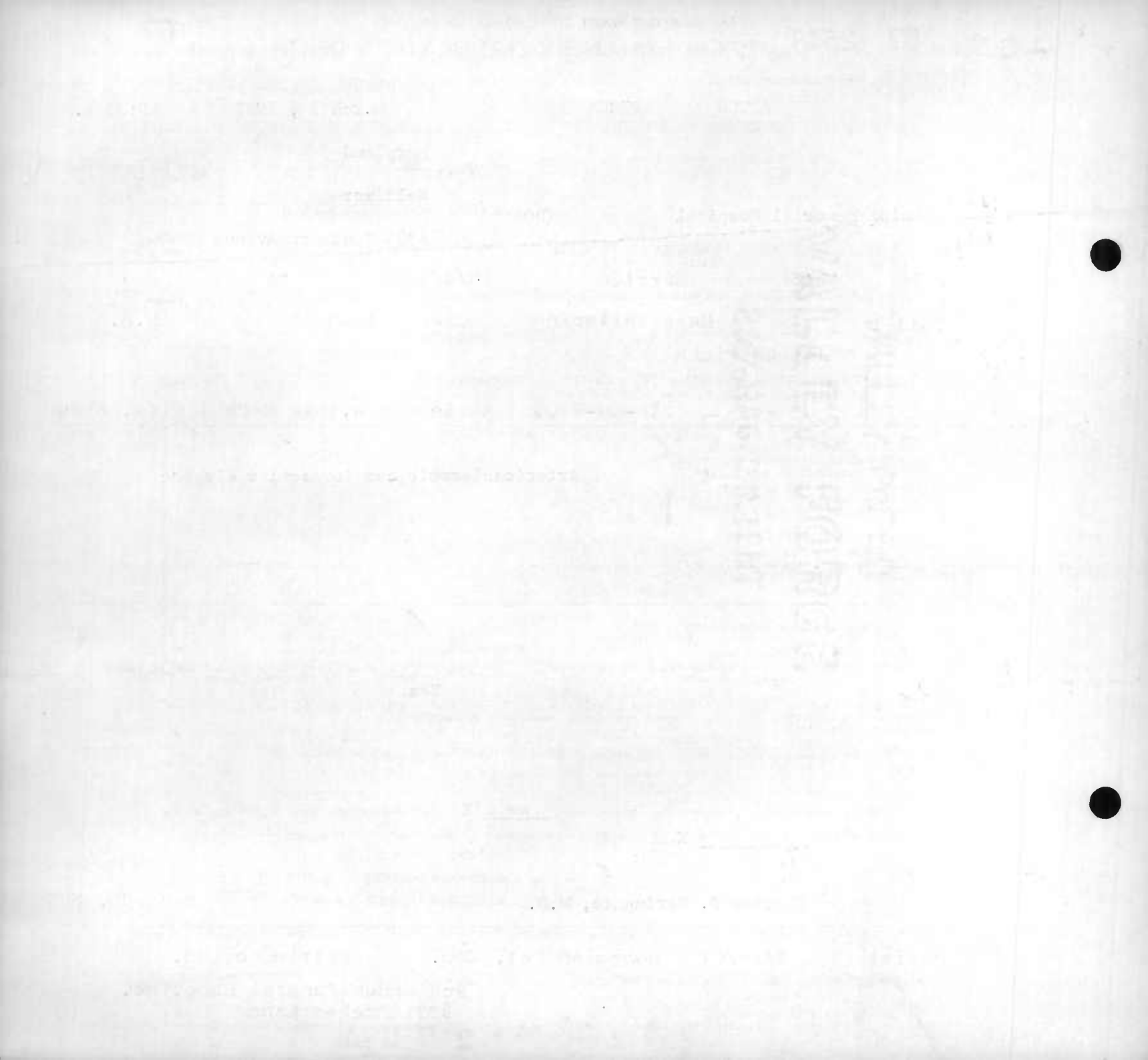
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2549	
BIRTH NO. 67 2549		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED FLORENCE A. WALLIS	
2. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION 412 N. Bouldin St. Baltimore, Md., 21224 3-23-67	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21224		5. DATE AND HOUR OF DEATH March 12, 1967 3 p. M.	
6. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-10		7. STREET ADDRESS (If rural, give location) 412 N. Bouldin St.	
8. SEX female	9. RACE white	10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced	11. DATE OF BIRTH 8th 1898 Aug. 18, 1898
12. AGE (In years lost birthday) 67 68		13. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. KIND OF BUSINESS OR INDUSTRY at home	
16. BIRTHPLACE (State or foreign country) Baltimore, Md.		17. CITIZEN OF WHAT COUNTRY?	
18. FATHER'S NAME Harrison Smith		19. MOTHER'S MAIDEN NAME Mary Ann Hughes	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		21. SOCIAL SECURITY NO.	
22. INFORMANT Robert Walls 3rd, 3013 Parktowne Rd. 34		ADDRESS	
18. 241X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) chronic asthma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe Bronchial Emphysema		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
23. DATE OF OPERATION 0	24. CONDITION FOR WHICH OPERATION WAS PERFORMED	25. AUTOPSY? (Yes or No)	26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	32. HOW DID INJURY OCCUR?	
33. I certify that (I) (this hospital) attended the deceased from July 1960 to 3/12 1967 , that (I) (we) last saw the deceased alive on 3/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
34. SIGNATURE Dr. Julius Goodman		35. DATE SIGNED 3/14/67	
36. PHYSICIAN'S NAME (Type) Dr. Julius Goodman		37. ADDRESS 3400 E. Baltimore St.	
38. BURIAL CREMATION, REMOVAL (Specify) Burial	39. DATE 3/15/67	40. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	41. LOCATION (City, town, or county) Baltimore, Md.
42. DATE REC'D BY HEALTH DEPT. MAR 15 1967	43. NAME OF REGISTRAR Philip E. Farley	44. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

2nd baptismal record
sent to church

3/10 3/15 3/17

John + Jane

3/10/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2550		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2550	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHNSON, HENRY OSWALD		2. DATE AND HOUR OF DEATH March 13, 1967		7:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2452 McCulloh St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-17-91	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric		11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Johnson		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 212-05-4632		17. INFORMANT Records V. A. Hospital, Baltimore, Md. 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 490X I Meningitis, organism unknown DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Right upper lobe pneumonia with abscesses DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 days 2 weeks					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 12, 1967 to March 13, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 13, 1967 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Barry N. Rosenbaum</i> BARRY ROSENBAUM M.D.				23B. DATE SIGNED March 14, 1967	
23C. PHYSICIAN'S NAME (Type) BARRY ROSENBAUM		23D. ADDRESS VA Hospital 3900 Loch Raven Blvd., Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-67		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l. Cem.	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR <i>Robert E. Spilhaus</i>		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calh	

Robert M. M. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 67 2551					CERTIFICATE OF DEATH					Registered No. 67 2551									
1. NAME OF DECEASED (Type or Print) MUSE, Randolph nmi					2. DATE AND HOUR OF DEATH 3/13/67 6:00 A M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 19-04 D. STREET ADDRESS (If rural, give location) 13 S. Fulton Avenue														
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 6/28/18		9. AGE (In years last birthday) 48		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10B. KIND OF BUSINESS OR INDUSTRY Boat Company					11. BIRTHPLACE (State or foreign country) Baltimore, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Muse					14. MOTHER'S MAIDEN NAME Mary Courtney														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/27/42 - 12/6/45					16. SOCIAL SECURITY NO. 220-03-1272		17. INFORMANT VA Hospital Records					ADDRESS 3900 Loch Raven Blvd., Balto., Md.							
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Cavitary Tuberculosis, left upper lobe of lung 2 months II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										(A) DUE TO		(B) DUE TO		(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) Yes					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (X) (this hospital) attended the deceased from February 10th 19 67 to March 13th 19 67 , that (X) (we) last saw the deceased alive on March 13th 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE LOUISE U. SULTAN										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED March 14, 1967				
23C. PHYSICIAN'S NAME (Type) LOUISE U. SULTAN					23D. ADDRESS VA Hospital 3900 Loch Raven Blvd., Balto., Md 21218														
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 3-17-67		24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l. Cem.					24D. LOCATION (City, town, or county) Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967					25B. NAME OF REGISTRAR Robert E. Taylor					25C. FUNERAL DIRECTOR Kelson Funeral Home-1348 Cal					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2552	
BIRTH NO. 67 2552		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Smith, Mrs. Glenwood		2. DATE AND HOUR OF DEATH 3/13/67 11:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21223	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) Bon Secour Hospital Baltimore 21223 Md.		D. STREET ADDRESS (If rural, give location) 410 N. Payson St		20-01	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-19-1924		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John H. Howard		14. MOTHER'S MAIDEN NAME Hancher Payne		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216243227		17. INFORMANT Ernest Smith (Husband)	
				ADDRESS 410 N. Payson	
18. 420, 114-2601		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO ACUTE MYOCARDIAL INFARCTION		HOURS	
ANTECEDENT CAUSES		(B) DUE TO CORONARY OCCLUSION		HOURS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD		YEARS.	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DIABETIS MELLITUS	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-12-1967 to 3-13-1967 , that (I) (we) lost saw the deceased alive on 3-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Agustin del Campo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 13, 1967	
23C. PHYSICIAN'S NAME (Type) AGUSTIN DEL CAMPO		23D. ADDRESS Bon Secour Hosp. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-17-67	24C. NAME OF CEMETERY or CREMATORY Church Cemetery		24D. LOCATION (City, town, or county) (State) Northumberland Co., Virg.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Adams		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calho	



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W-636 67 2553		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2552	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ulysses Wharton</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		2. DATE AND HOUR OF DEATH <i>3-13-67</i> <i>3:56 A.M.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1718 E. 31st Street - #21218	
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 2-22-11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME <i>Ulysses Wharton</i>		14. MOTHER'S MAIDEN NAME EMMA		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT #21224 RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
18. <i>42011</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Myocardial Infarction</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2-27</i> 19 <i>67</i> to <i>3-13</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3-12</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David J. Mishelevich</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>3-13-67</i>	
23C. PHYSICIAN'S NAME (Type) DR. DAVID J. MISHELOVICH M.D.				23D. ADDRESS #21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>3-18-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenwood</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		24E. DATE REC'D BY HEALTH DEPT. MAR 15 1967		24F. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
24G. FUNERAL DIRECTOR <i>George Wilson</i>		24H. ADDRESS <i>1020 Bunting St</i>		24I. DATE OF DEATH <i>3-13-67</i>	



1
F-630

67 2554

BALTIMORE CITY HEALTH DEPARTMENT

67 2554

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		HATTIE FORD		2. DATE AND HOUR PRONOUNCED DEAD March 11, 1967 4:05 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 1408 Whitelock Street				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 13-03 D. STREET ADDRESS (If rural, give location) 1408 Whitelock Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Aug 23, 1908	9. AGE (in years last birthday) 58	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Simpson Boster		14. MOTHER'S MAIDEN NAME Isabella Wineglass		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Louis Boster ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/12/67					
23A. BURIAL CREMATION, REMOVAL (Specify) Buried		23B. DATE 3-16-67		23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cent	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR Edgar E. Jackson		24C. FUNERAL DIRECTOR Clay Wilson 1001 Broadway Ave	
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (State) MD			

MAR 15 1967

2562

WALLACE BOWLER

CHIEF CLERK

F-222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY SYKES (Fosy Kes)		3/13/67 11:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY		
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			MARYLAND		
5. SEX FEMALE			6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5/20/04
13. FATHER'S NAME JOHN BOWSON			14. MOTHER'S MAIDEN NAME SUSIE Warmac		9. AGE (In years last birthday) 62
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) W			16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMATION			ADDRESS		
RECORDS BALTO. CITY HOSPITALS			4940 EASTERN AVENUE, BALTO., Md. 21224		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO Chronic renal disease		INTERVAL BETWEEN ONSET AND DEATH 8 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO heart failure		15 years
			(C) DUE TO hypertension		7 10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/8 19 67 to 3/13 19 67, that (II) (we) last saw the deceased alive on 3/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (II) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Swimmer M.D.				23B. DATE SIGNED 3/13/67	
23C. PHYSICIAN'S NAME (Type) DAVID SWIMMER M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-67		24C. NAME OF CEMETERY or CREMATORY Arlington Park	
24D. LOCATION (City, town, or county) Lanham		24E. LOCATION (State) MD			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Elroy C. Taylor	
				ADDRESS 1000 Brambley he	



B-650

67 2556

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2556

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

(THEODORE) CAREY E. BROWN

2. DATE AND HOUR PRONOUNCED DEAD

March 13, 1967 8:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If NOT in HOSPITAL or INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lafayette

624 W. Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Q.A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Severn

D. STREET ADDRESS (If rural, give location)

Earleigh Heights

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWER, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

May 26, 1900

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Reisterstown, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Eugene Brown

14. MOTHER'S MAIDEN NAME

Ardella Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Evelyn Daniels - 1154 N. Longwood St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/14/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-17-67

23C. NAME of CEMETERY or CREMATORY

St. Lukes

23D. LOCATION

(City, town, or county)

(State)

Reisterstown, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 15 1967

Robert E. Farley

Charles R. Law 802 Madison Ave.

WALLACE TROUBLE

APR

WALLACE TROUBLE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2557</u>	
BIRTH NO. <u>67 2557</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Anna (SUGERMAN) SUGARMAN</u>		2. DATE AND HOUR OF DEATH <u>March 15, 1967 4:10 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Boston Rice Nursing Center</u> <u>90</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2906 Whitney Ave.</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 15, 1901</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Leopold LEBAUER</u>		14. MOTHER'S MAIDEN NAME <u>Isby ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-03-5279</u>		17. INFORMANT <u>M'S SADIE KOHN, 2906 WHITNEY AVENUE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>450.01</u>		CAUSE OF DEATH (A) <u>Pneumonia; Pleural effusion</u> (B) <u>Chronic Brain Syndrome</u> (C) <u>Arteriosclerosis, generalized congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>years</u> <u>years</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u> <u>no</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> 19 <u>67</u> to <u>3/15</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/14</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ALLAN H. MACHT</u> M.D.				23B. DATE SIGNED <u>3/15/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT</u> M.D.				23D. ADDRESS <u>2 EAST READ ST 21402</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/16/67</u>		24C. NAME of CEMETERY or CREMATORY <u>ADATH JESHURUN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1967</u>			
25B. NAME OF REGISTRAR <u>Adath Jeshurun</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>			

RECEIVED
JAN 10 1964

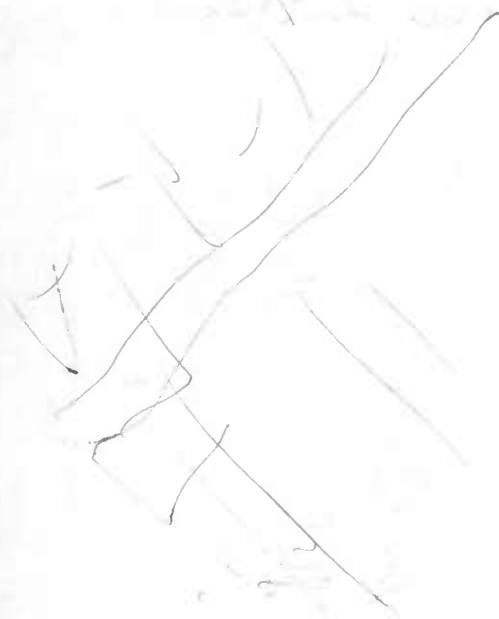
ALAN H. WACH
C. M. W.

2 EAST KEARNEY ST
CHICAGO, ILL.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2558		CERTIFICATE OF DEATH		Registered No. 67 2558	
1. NAME OF DECEASED (Type or Print) Mable Acklin				2. DATE AND HOUR OF DEATH 3-8-67		10:45 P.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital, Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, D. STREET ADDRESS (If rural, give location) 615 Dolphin Street					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 1897	9. AGE (In years last birthday) 70 yrs.	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Smith				14. MOTHER'S MAIDEN NAME Kate Watts					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Lola Hand		ADDRESS 3033 Southland ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) 587.0 I				CAUSE OF DEATH (A) Pulmonary edema DUE TO (B) Acute pancreatitis DUE TO (C) Frost bite				INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from March 5, 19 67 to March 8, 19 67 , that (I) (we) last saw the deceased alive on March 8, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. Khaliq				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-9-67			
23C. PHYSICIAN'S NAME (Type) A. Khaliq,				23D. ADDRESS M.D. 1514 Division Street Balto., Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE RECEIVED BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR William S. Phillips		ADDRESS 1727 M. Ave.			



1. 10/10/10

B-620

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 2559		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2559	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
ROLAND B. BRISCOE		March 11, 1967 9:39 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 1802 Presstman Street 00		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-62 D. STREET ADDRESS (If rural, give location) 1802 Presstman Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Jan. 3, 1927
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 40
13. FATHER'S NAME Charles Briscoe		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY?
17. INFORMANT Vernon Briscoe		14. MOTHER'S MAIDEN NAME Carrie Scribner	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 422.1 CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		20A. AUTOPSY? (Yes or No) Yes	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/14/67	
23C. NAME of CEMETERY or CREMATORY Baltimore National		23D. LOCATION (City, town, or county) (State) Baltimore Md.	
24A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		24B. NAME OF REGISTRAR Robert E. Fawcett	
24C. FUNERAL DIRECTOR Wilmington Phillips		24D. ADDRESS 1727 N. Mount	

LETTER

NO. 1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2560	
BIRTH NO. 67 2560		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VIOLA C. HARRIS		2. DATE AND HOUR OF DEATH 3-9-67 4:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		A. STATE MARYLAND		B. COUNTY BALTIMORE	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
		639 N BENTALOU ST.		16-05	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-25-98	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Jacob Pulley		14. MOTHER'S MAIDEN NAME Cynthia Wright	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-320094		17. INMATE ADDRESS John N. Harris Same	
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) EVA		(A) DUE TO Hypertension		(B) DUE TO Diabetes Mellitus	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-8-67 to 3-9-67 , that (I) (we) lost saw the deceased alive on 3-9-67 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas C. Vidnyaphum M.D.		23B. DATE SIGNED 3-9-67		23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDNYAPHUM M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/67		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Ch. Bacteriary Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Washington Shelly ADDRESS 1727 M. Mount	

Handwritten text, possibly a signature or date, located in the upper center of the page.

(2)

Handwritten text at the bottom of the page, possibly a date or reference number.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STACI G. ROOKS

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1967 4:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2504 Forest Park Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

600 Winston Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Aug. 23/1963

9. AGE (In years
last birthday)

3

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ronald Rooks

14. MOTHER'S MAIDEN NAME

Guendolyn Giles

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ronald Rooks

Same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
Granulosa cell tumor of right ovary
with torsion of pedicle, hemorrhage
and rupture into peritoneal cavity

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/12/67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk. Baltimore

23D. LOCATION

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

William J. Phillips 1727 N. Mount St.

ADDRESS

8

WALBURY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2562	
BIRTH NO. 67 2562		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles E. Matthews		2. DATE AND HOUR OF DEATH March 8, 1967 3 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-03		
			D. STREET ADDRESS (If rural, give location) 1627 Lafayette Ave		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4/6/00	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kennett Co., MD.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown Wm. Matthews			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 22030-0221		17. INFORMANT Anna Myers 725 N. Fremont Ave
18. I 155.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Hepatic Cholangione DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ??
19A. DATE OF OPERATION 2/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 6, 1967 to March 8, 1967 , that (I) (we) last saw the deceased alive on March 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. H. Anderson				23B. DATE SIGNED 3/8/67	
23C. PHYSICIAN'S NAME (Type) R. H. Anderson				23D. ADDRESS University Hospital Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967			
25B. NAME OF REGISTRAR Charles E. Matthews		25C. FUNERAL DIRECTOR Arlington Phillips 1727 N. Monaca			

13

Received of the Treasurer of the
Board of Directors of the
City of New York
the sum of \$100.00
for the purchase of
the City of New York
the sum of \$100.00
for the purchase of
the City of New York

Witness my hand and seal
this 1st day of January
1881
Mayor of the City of New York

Received of the Treasurer of the
Board of Directors of the
City of New York
the sum of \$100.00
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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2564	
CERTIFICATE OF DEATH					
BIRTH NO. 64 1067 2564		M.E. CASE NO.			
1. NAME OF DECEASED DENEEN				2. DATE AND HOUR OF DEATH	
Denine W. Gibbs				3/7/67 5:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
33 The Johns Hopkins Hospital				Maryland	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				2948 Clifton Avenue	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro	Child	4/24/64	2	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Donald W. Gibbs			Vera Lewis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Donald Gibbs Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) Aspiration pneumonia	
ANTECEDENT CAUSES				(B) Respiratory Insufficiency	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(C) Pontocerebellar Degeneration	
INTERVAL BETWEEN ONSET AND DEATH				48 hours	
				6 weeks	
				16 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
FEB 2 1967		TRACHEOSTOMY		Yes	
FEB 15 1967		FEEDING GASTROTOMY		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from January 24 1967 to March 7 1967, that (I) (we) last saw the deceased alive on March 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. Swick M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				3/7/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. Swick M.D.				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3/10/67		Baltimore National Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 15 1967		Robert E. Taylor		Washington S. Phillips 1727 N. Mount St.	

B-460

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 2565		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2565	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
		Earl Boller	
2. DATE AND HOUR PRONOUNCED DEAD		3/4/67 6:20 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland	
39 Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1607	
D. STREET ADDRESS (If rural, give location) 1513 Poplar Grove St.			
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Oct. 11, 1937
9. AGE (In years last birthday) 29		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Boller		14. MOTHER'S MAIDEN NAME Annie Ross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Rosabell Williams	
		ADDRESS Same	
18. 581.0 I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Fatty alteration of liver	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO	
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/5/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/8/67	
23C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		23D. LOCATION (City, town, or county) (State) Md.	
24A. DATE REC'D BY HEALTH DEPT. MAR 15 1967		24B. NAME OF REGISTRAR Robert E. Frazier, M.D.	
24C. FUNERAL DIRECTOR Arlington Funeral Home		24D. ADDRESS 1727 N. Mon	

Sept 1931

Life

Wagon
Camp

My dear

My dear

Wagon
Camp

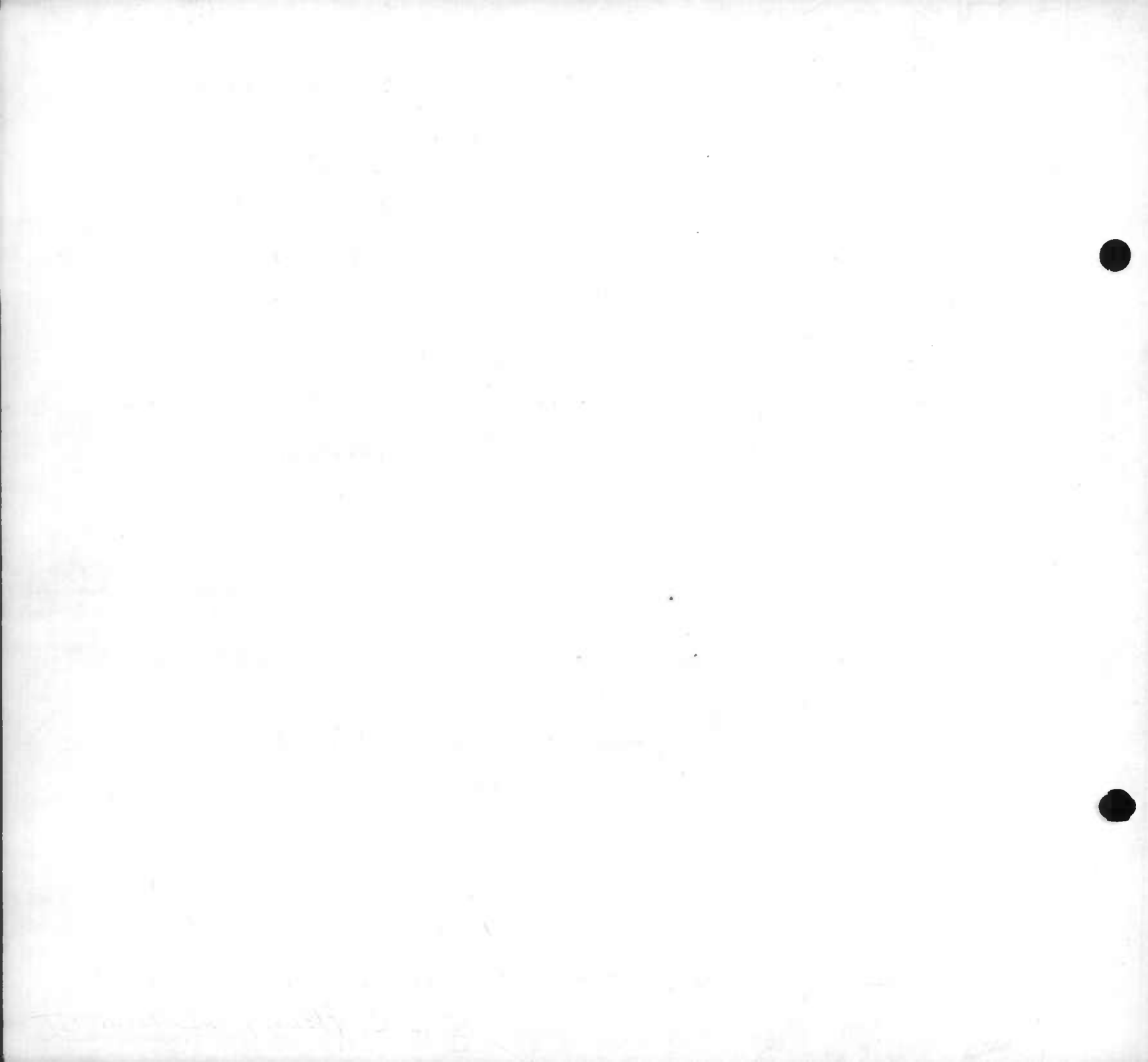
Wagon

Wagon
Camp

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2566	
BIRTH NO. 67 2566		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Alvin R. Miller</i>		2. DATE AND HOUR OF DEATH <i>MARCH 13, 1967</i> 6PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00407 ARSON AVE</i>		A. STATE <i>MD</i> B. COUNTY <i>25-04</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
		D. STREET ADDRESS (If rural, give location) <i>407 ARSON AVE</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED , NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>Sept 13, 1892</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman of Loading Rack</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>American Oil Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>George Miller</i>		14. MOTHER'S MAIDEN NAME <i>Emily Grof</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>WWI Army</i>		16. SOCIAL SECURITY NO. <i>213-05-3643</i>		17. INFORMANT <i>Margaret E. Hoffman</i>	
18. <i>451 X 1</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Ruptured abdominal aortic aneurysm</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>August 1966</i> to <i>March 13, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 13, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ricardo Lozada</i>				23B. DATE SIGNED <i>3/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ricardo Lozada</i>				23D. ADDRESS <i>1228 S. Charles St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>Mar. 17, 1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE NATIONAL</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Ann S. Fleming</i>	
				ADDRESS <i>1422 LIGHT ST</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2567				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2567	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Helen T. Schenning</i>		2. DATE AND HOUR OF DEATH <i>3-13-1967 1:50 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>24-01</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>1442 Towson Street</i>			
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6-18-08</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY -----			11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Patrick Coleman</i>			14. MOTHER'S MAIDEN NAME <i>Ellen Hannon</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. -----		17. INFORMANT <i>John J. Schenning</i>		
			ADDRESS <i>1442 Towson St.</i>				
18. <i>331 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cerebro Vascular Accident</i>				CAUSE OF DEATH (A) DUE TO <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that at (this hospital) attended the deceased from <i>3-8</i> 19 <i>67</i> to <i>3-13</i> 19 <i>67</i> , that at (we) last saw the deceased alive on <i>3-13</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Rose J. Glunas</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-13-1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rose J. Glunas</i>				23D. ADDRESS <i>South Baltimore General Hospital</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/16/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens</i>		ADDRESS <i>2501 East Fort Avenue</i>	



FUNERAL DIRECTOR: IMPORTANT

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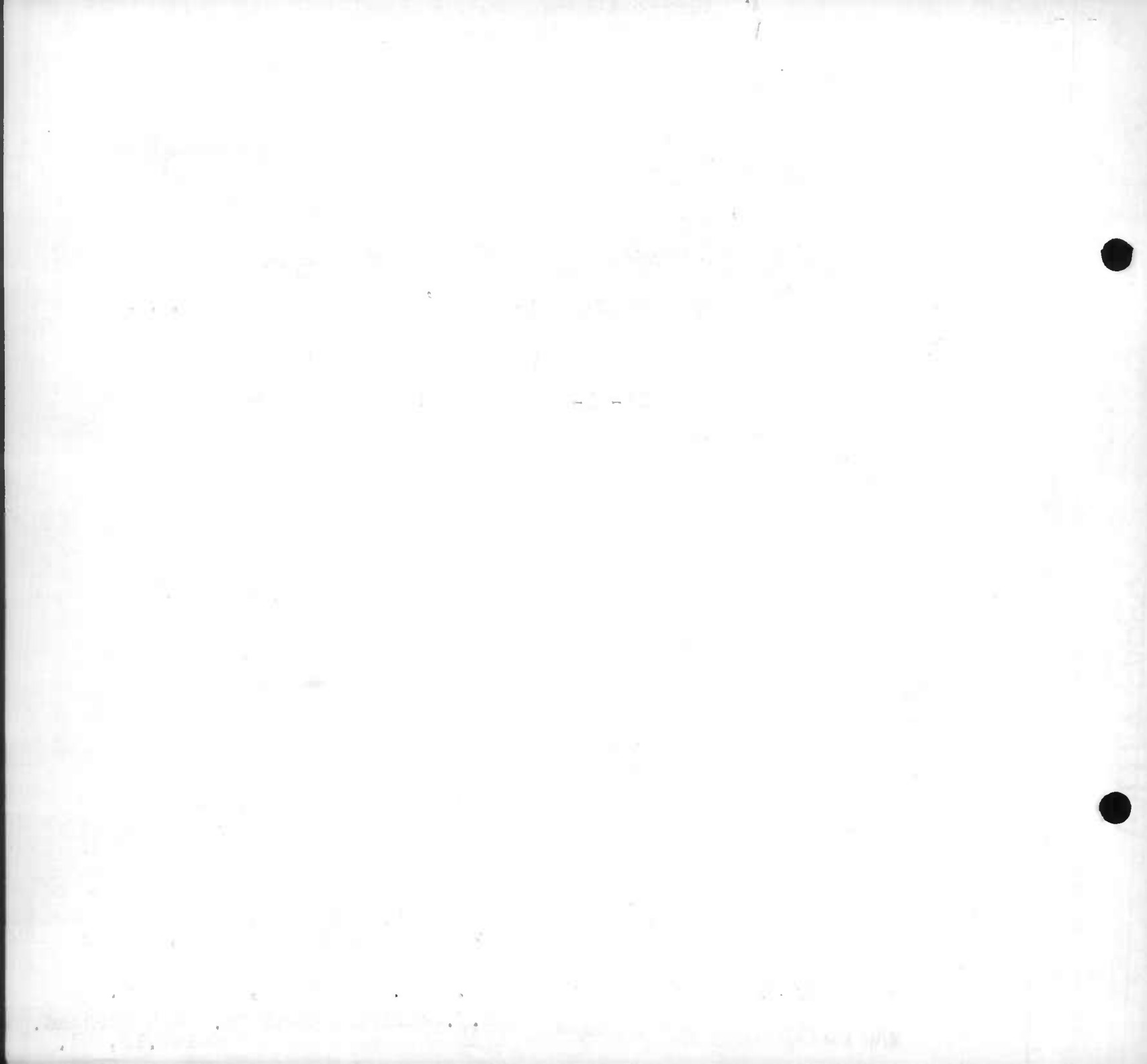
BALTIMORE CITY HEALTH DEPARTMENT																			
67 2568					CERTIFICATE OF DEATH					Registered No. 67 2568									
BIRTH NO. 67 2568					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) : POWELL, ROBERT					2. DATE AND HOUR OF DEATH 3-14-67 TUES 3:40 a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					5. CITY OR TOWN (If outside city limits, write RURAL and give township)					6. STREET ADDRESS (If rural, give location)				
FULL NAME OF HOSPITAL OR INSTITUTION: COLTON WILL NURSING CENTER 1400 JOHN STREET 90 BALTIMORE, MARYLAND 21217					A. STATE MARYLAND					B. COUNTY BALTIMORE					C. CITY OR TOWN BALTIMORE 21230				
D. STREET ADDRESS 1321 South CHARLES ST.					7. MARIED, NEVER MARIED, WIDOWED, DIVORCED (specify) DIVORCED					B. DATE OF BIRTH 3-15-05					9. AGE (In years lost birthday) 61				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER					10B. KIND OF BUSINESS OR INDUSTRY H. H. Le SALE PRODUCE					11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ROBERT LEE POWELL					14. MOTHER'S MAIDEN NAME FLORENCE HACHBEE					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 218-10-4689				
17. INFORMANT MARY HUCKBEE					ADDRESS					18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					INTERVAL BETWEEN ONSET AND DEATH 3-4 mo.				
19. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from 11-11-1966 to 3-14-1967, that (I) (we) last saw the deceased alive on 3-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					23A. SIGNATURE H. Nakazawa M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				
23B. DATE SIGNED 1-14-67					23C. PHYSICIAN'S NAME (Type) HIROSHI NAKAZAWA M.D.					23D. ADDRESS 3350 WILKENS AVE MD. 21229					24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				
24B. DATE SAT. MARCH 1967					24C. NAME OF CEMETERY OR CREMATORY Mt. OLIVET - BALTOY MD.					24D. LOCATION (City, town, or county) (State) CURTIS E. EVANS					25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967				
25B. NAME OF REGISTRAR Robert E. Taylor					25C. FUNERAL DIRECTOR 14005, CHARLES					25D. ADDRESS 21230									

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2569		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2569	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Carl J. Rankin</u>		2. DATE AND HOUR OF DEATH <u>3/13/67</u> <u>1425</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
		D. STREET ADDRESS (If rural, give location) <u>308 Evesham Avenue</u> <u>21212</u>		<u>27-12</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-15-04</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Western Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Luke, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Capitola Simpson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-2880</u>		17. INFORMANT <u>RECORDS: BCH 4940 Eastern Avenue 21224</u>	
18. <u>430.1 260x</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Diabetes mellitus</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/13/67</u> 19 to <u>3/13/67</u> 19 that (I) (we) last saw the deceased alive on <u>3/13</u> 19 <u>67</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William A. Emerson</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>William A. Emerson</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/16/1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley Mem. Grds.</u>	
24D. LOCATION (City, town, or county) (State) <u>Timonium, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1967</u>		25B. NAME OF REGISTRAR <u>R. E. Faldut</u>	
25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		25D. ADDRESS <u>4905 York Rd.</u>		<u>Balto. 12, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2570	
BIRTH NO. 67 2570		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edna. V. Lovell		2. DATE AND HOUR OF DEATH 3/12/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3607 Chestnut Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 3607 Chestnut Ave.			
5. SEX Fe.	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/23/98	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressor		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 212-10-3097		17. INFORMANT Rita Yaffe 3607 Chestnut Ave.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Myocardial infarction (B) DUE TO Arteriosclerosis (C) Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH a few hours 3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 10 1951 to March 12 1967 that (I) (we) last saw the deceased alive on March 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. W. A. L. E. N. S. T. E. R. N.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/14/67	
24A. PHYSICIAN'S NAME (Type) L. W. A. L. E. N. S. T. E. R. N.		24B. ADDRESS 848 W 36th St Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/67		24C. NAME OF CEMETERY or CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Paul E. Charnick		ADDRESS 3617 Chestnut Ave.	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.F-425 67 2571
BIRTH NO. 67-00428
M.E. CASE NO.

67 2571

1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD									
CRAIG FAULCON				March 13, 1967 8:25 P M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland B. COUNTY									
33 Johns Hopkins Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore									
				D. STREET ADDRESS (If rural, give location) 5003 Govane Avenue									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.			
Male		Negro				1/1/67				2			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
child								Maryland					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
John Luerter				Isabelle Sans									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no						Mrs Brown 1328 Potomac St							
18. CAUSE OF DEATH												INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)													
(A) Interstitial Pneumonitis (SDII). DUE TO													
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.													
(B) DUE TO													
(C) DUE TO													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
								Yes		Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				Charles S. Petty				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type)								M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				4/14/67	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>													
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE		23C. NAME of CEMETERY or CREMATORY				23D. LOCATION (City, town, or county) (State)			
Burial				3/16/67		Mt. Auburn Cemetery				Baltimore Md			
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR				24C. FUNERAL DIRECTOR				ADDRESS	
MAR 15 1967				R. E. F. Adams				Adolphus Halstead				1206 W North Ave	

THE FIRST 1000 YEARS

THE FIRST 1000 YEARS

THE FIRST 1000 YEARS

45-83-43 1B

G-355 67 2572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2572

BIRTH NO. 67 2572		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Goodman Mary</i>		2. DATE AND HOUR OF DEATH <i>3/13/67 10³⁰ P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 25-32</i> D. STREET ADDRESS (If rural, give location) <i>833 BETHUNE ROAD #21225</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>DIVORCED</i>	8. DATE OF BIRTH <i>3-9-15</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>52</i>
13. FATHER'S NAME <i>SAMUEL ANDERSON</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>MD. 21224 RECORDS #4940 EASTERN AVENUE, BALTIMORE</i>
18. <i>170 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Metastatic carcinoma</i> DUE TO (B) <i>of the breast</i> DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in city, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>3/10 1967</i> to <i>3/13 1967</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>3/13 1967</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(I) (We) (did)</i> (did not) view the body after death.			
23A. SIGNATURE <i>R. J. Owellen</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-13-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. R. J. OWELLEN</i>		23D. ADDRESS <i>BCH-4940 EASTERN AVENUE, BALTIMORE, MD. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>3/18/67</i>	24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1967</i>	25B. NAME OF REGISTRAR <i>Adolphus Halstead</i>	25C. FUNERAL DIRECTOR <i>1206 W North Ave</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2573		CERTIFICATE OF DEATH		Registered No. 67 2573	
1. NAME OF DECEASED (Type or Print) Fred D. DARDEN				2. DATE AND HOUR OF DEATH 3-11-67 2:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. Gen'l Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY —					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 14-02					
				D. STREET ADDRESS (If rural, give location) 1700 Eutan Place					
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 9-15-00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME LONNIE DARDEN				14. MOTHER'S MAIDEN NAME Phyllis ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 20005047		17. INFORMANT Wife			
				ADDRESS					
18. 331 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Sub ARACHNOID Hemorrhage 3-4-67 (?) (B) AACVD (C) Intra cerebral Hemorrhage (R) and ruptured 10 subarachnoid space					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				INTERVAL BETWEEN ONSET AND DEATH due to Hypertensive arteriosclerotic cerebral vascular disease					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MARCH 4 19 67 to MARCH 11 19 67 , that (I) (we) last saw the deceased alive on MARCH 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Dean H. Guff						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-11-67	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/67		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 16 1967		Adolphus Halstead		Adolphus Halstead		1206 W North Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 2574				
BIRTH NO. 67 2574					M.E. CASE NO. 67 2574				
1. NAME OF DECEASED (Type or Print) Lillie Mae Ross					2. DATE AND HOUR OF DEATH 12 March 1967 9:50 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND University Hospital HOSPITAL OR INSTITUTION (If in hospital, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Baltimore City A. STATE B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1753 N. Gay Street				
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1930	9. AGE (In years lost birthday) 37	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Fort Myers, Florida		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Abbott Jones					14. MOTHER'S MAIDEN NAME CORA LEE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS David J. Ross 1753 N. Paca St.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 247X I Respiratory Insufficiency Acute Asthmatic Attack					INTERVAL BETWEEN ONSET AND DEATH not known not known				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 12 Mar 1967 to same date that (I) (we) last saw the deceased alive on DOA and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Sidney L. Stapleton, Jr. M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12 March 1967	
23C. PHYSICIAN'S NAME (Type) Sidney L. Stapleton, Jr.					23D. ADDRESS University Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/67		24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md, Baltimore			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 2575	
CERTIFICATE OF DEATH					
BIRTH NO. 255 67 2575		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>The Late Ida Luckman</u>			2. DATE AND HOUR OF DEATH <u>3/15/67</u> <u>1:00</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>123 SOUTH BROADWAY</u>		
5. SEX <u>7</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>2-1-03</u>	9. AGE (In years lost birthday) <u>64</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO, MD</u>	
13. FATHER'S NAME <u>MAX</u>			14. MOTHER'S MAIDEN NAME <u>CECELIA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>ROBERT HARRISON 508 Tower Bldg</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>296X I</u>			CAUSE OF DEATH (A) <u>Respiratory & Cardiac arrest</u> (B) <u>Intestinal hemorrhage</u> (C) <u>Hemorrhagic diathesis</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Anti-ANG clotting defect</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> 19 <u>66</u> to <u>3/15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Kenneth L. Brigham</u>				23B. DATE SIGNED <u>3/15/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kenneth L. BRIGHAM</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/16/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	
24D. LOCATION (City, town, or county) <u>Balto,</u>		24E. LOCATION (State) <u>Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1967</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Sylvester S. Lewis & Son</u>		25D. ADDRESS <u>Garrison, Md</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. M.E. CASE NO.		67 2576		67 2576	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Louis Dollinger			March 12, 1967 10:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4311 Walther Avenue			A. STATE Maryland		
			B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-01		
			D. STREET ADDRESS (If rural, give location) 4311 Walther Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	May 30, 1897	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Plumber		Self-Employed		Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
William Dollinger			U.S.A.		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
Anna Benschel			Yes		
16. SOCIAL SECURITY NO.			17. INFORMANT		
218-32-3996			Grace M. Dollinger - 4311 Walther Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Myocardial Infarction		minutes
			(B) DUE TO Coronary Arteriosclerosis		5 yrs.
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Diabetes Mellitus		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from August 17 1956 to March 12 1967, that (I) (we) last saw the deceased alive on March 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
LESTER A. WALL JR.				3/13/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
LESTER A. WALL JR.				1039 St. Paul St 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3-15-67		Baltimore National Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 16 1967		Charles E. Taylor		John C. Miller Inc-6415 Belair Road-21206	

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Myocardium infarctum

Coronary Atherosclerosis

Subacute

to

Group 1 of 10

Group 2 of 10

Letter A

Letter A

10.10.10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2577	
BIRTH NO. 67 2577		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Margaret E. Filliaux		2. DATE AND HOUR OF DEATH 13 March 1967 245 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2607			
D. STREET ADDRESS (If rural, give location) 625 S. Newkirk St. #21224					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 23 June 1881	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John HARTMAN		14. MOTHER'S MAIDEN NAME Susan Lenhardt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-48-8795		17. INFORMANT #21224 RECORDS-BCH-4940 EASTERN AVENUE	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebrovascular Thrombosis DUE TO (B) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 30 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Emphysema, Gastrointestinal Bleeding					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 12 March 1967 to 13 March 1967, that (1) (my) last saw the deceased alive on 13 March 1967 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Alan J. Barnes M.D.		23B. DATE SIGNED 13 March 1967			
23C. PHYSICIAN'S NAME (Type) DR. ALAN J. BARNES		23D. ADDRESS MD. BCH-4940 EASTERN AVENUE, BALTIMORE,			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-16-67		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM.	
24D. LOCATION 7401 GERMAN HILL RD. BALTO., 24, MD.					
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR R. E. G. Taylor		25C. FUNERAL DIRECTOR Charles S. Geiler	
25D. ADDRESS 901 S. CONKLIN ST. BALTO., 21224, MD.					

54

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2578		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2578	
M.E. CASE NO. 144		1. NAME OF DECEASED (Type or Print) DORSEY, LAVINA AUGUSTA		2. DATE AND HOUR OF DEATH MARCH 12, 1967 7:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTO., MD. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21227 D. STREET ADDRESS (If rural, give location) 5118 SHELBOURNE ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 09-21-84	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE Nally		14. MOTHER'S MAIDEN NAME SARAH Magaha	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 223-12-8204		17. INFORMANT BALTO., MD. 21229 ST. AGNES RECORDS - WILKENS & CATON	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that X (this hospital) attended the deceased from FEBRUARY 19, 1967 to MARCH 12, 1967 , that X (we) lost saw the deceased alive on MARCH 12, 1967 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (XXX) view the body after death.		23B. DATE SIGNED 3/12/67	
23A. SIGNATURE John B. Herts		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. PHYSICIAN'S NAME (Type) JOHN B. HERTS,	
23D. ADDRESS WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTO., MD. 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/67	
24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED HEALTH DEPT. MAR 16 1967	
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave. 21229	

Figure 1. The effect of the concentration of the solution on the adsorption of the dye.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 2579				
BIRTH NO. 67 2579					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Lee John P.					2. DATE AND HOUR OF DEATH 3-14-67 6:05 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt Co				
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital 49					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21234				
					D. STREET ADDRESS (If rural, give location) 2515 Wendover Road 53-00				
5. SEX Male	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-24-14	9. AGE (in years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BORING FOREMAN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Deceased John P. Lee					14. MOTHER'S MAIDEN NAME Deceased Josephine M. Nichols				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II			16. SOCIAL SECURITY NO. 212-03-4491		17. INFORMANT ADDRESS North Charles General Hospital				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 3-27-11 Severe emphysema and chronic respiratory insufficiency G-I hemorrhage low grade focal infection					INTERVAL BETWEEN ONSET AND DEATH many years 12 days post op for 12 days				
19. DATE OF OPERATION 3-2-67					20. AUTOPSY? (Yes or No) No				
21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) GI bleeding					22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No				
23. SIGNATURE S. S. Morarath					24. DATE SIGNED 3-14-67				
25. NAME OF REGISTRAR MAR 16 1967					26. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229				
27. BURIAL CREMATION, REMOVAL (Specify) Burial					28. DATE 3-17-1967				
29. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery					30. LOCATION (City, town, or county) (State) Baltimore, Maryland				

1. The first of these is the

John F. Kennedy

Page 11

Page 12

1-17-77 11:00 AM

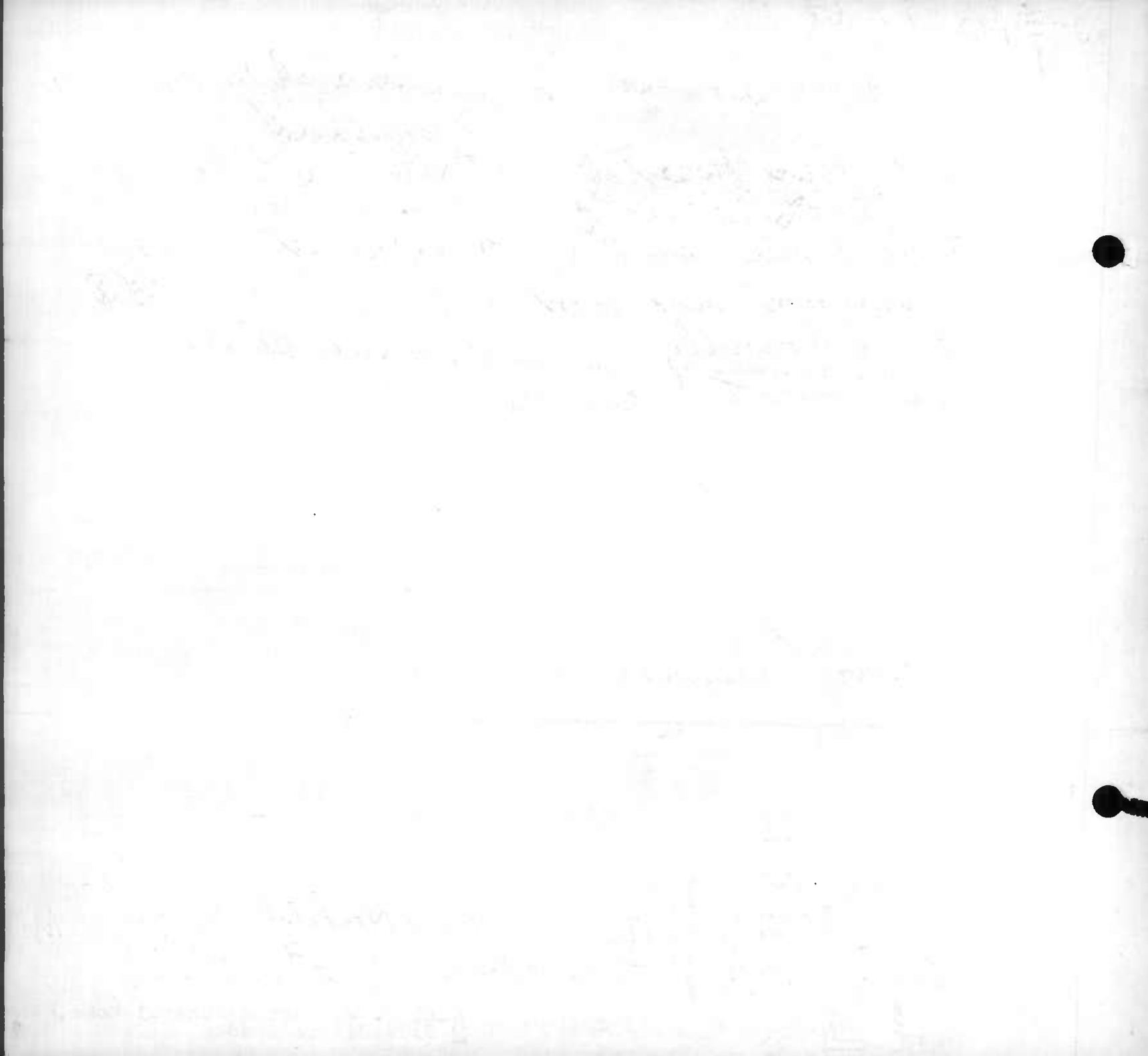
Page 13

1-17-77 11:00 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2580		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2580	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) DOUGNELLY, JAMES				March 12, 1967 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 361 - St Paul Place Baltimore 21202, Md		A. STATE Maryland B. COUNTY Baltimore City			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	
8. DATE OF BIRTH April 24, 1908		9. AGE (In years last birthday) 58		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Baltimore - Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Donnelly		14. MOTHER'S MAIDEN NAME Catherine Shields	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO. 216-07-2966		17. INFORMANT Records - V.A. ADDRESS	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Brain stem failure DUE TO (B) Brain stem compression DUE TO (C) Intracerebral hematoma, (2) traumatic, spontaneous		INTERVAL BETWEEN ONSET AND DEATH 8 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3/4/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracerebral hematoma		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/4 1967 to 3/12 1967, that (I) (we) last saw the deceased alive on 3/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE Ronald T Paul		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/12/67	
23C. PHYSICIAN'S NAME (Type) RONALD T PAUL		23D. ADDRESS Mercy Hospital, Baltimore - Md			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore 21202, Md		24E. FUNERAL DIRECTOR Earl B. Wolverton		ADDRESS 6306 Belair Road	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR R. E. Faden		25C. FUNERAL DIRECTOR Earl B. Wolverton	



1
N-400

67 2581

BALTIMORE CITY HEALTH DEPARTMENT

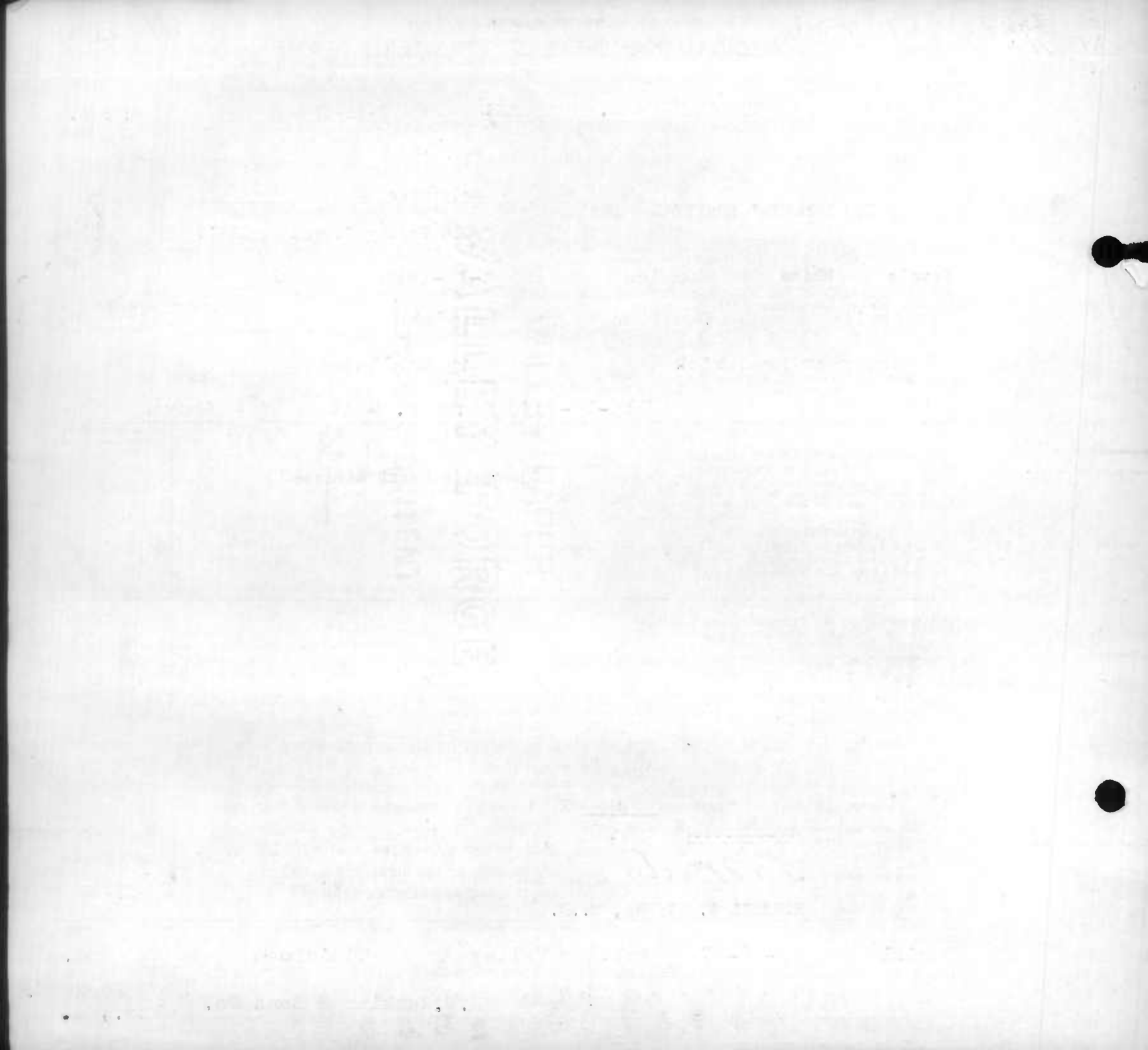
67 2581

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		CAROLINE L. NOLL		2. DATE AND HOUR PRONOUNCED DEAD 3-15-67 8:25 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 99 UNION MEMORIAL HOSPITAL - DOA				A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3018 Frisby Street 21218	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-18-1920	9. AGE (In years last birthday) 47	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Christopher Frederick			14. MOTHER'S MAIDEN NAME Mary Smallwood		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-16-9330		17. INFORMANT Henry G. Noll ADDRESS Above	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 416X Rheumatic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>R. S. Fisher</i> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-15-67					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-18-67		23C. NAME of CEMETERY or CREMATORY Dulaney Valley	
24A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		24B. NAME OF REGISTRAR R. S. Fisher		24C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2582				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2582	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mrs Margaret J. Egan</i>				2. DATE AND HOUR OF DEATH <i>3/15/67</i> <i>7:00 PM</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bould Convalesarium</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>21212</i> D. STREET ADDRESS (If rural, give location) <i>5511 Purdue Ave</i> <i>27-38</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/29/82</i>	9. AGE (In years lost birthday) <i>84</i>	If Under 1 Yr. Months Days Hours Min. <i>7</i> <i>15</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife - retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Altoona Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William H Jones</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Doyle</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>164-28-4494</i>		17. INFORMANT <i>W. M. Conway mrs see below</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>MI, recurrent</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>myocardial infarction</i> <i>Arterio Sclerosis, Systemic</i> <i>Bleeding blood, Secondary Anemia</i>				CAUSE OF DEATH A) DUE TO B) DUE TO C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>3 months</i> <i>10 years</i> <i>2 1/2 months</i>	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <i>12/28/66</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>fracture neck of femur</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Walking in living room of home</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 20</i> 19 <i>66</i> to <i>March 15</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 15</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>W. M. Conway mrs</i>						23B. DATE SIGNED <i>3/15/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. M. Conway mrs</i>				23D. ADDRESS <i>8358 Loch Raven Blvd Towson Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-18-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cathary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Altoona Pa</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1967</i>		25B. NAME OF REGISTRAR <i>P. G. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Loyley Corp</i>		ADDRESS <i>7200 Harford Road</i>	



15
L-520

67 2583

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2583

BIRTH NO. 67 2583

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) PATRICK J. LYNCH

2. DATE AND HOUR PRONOUNCED DEAD March 13, 1967 6:32 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 7 E. Eager Street

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

7. STREET ADDRESS (If rural, give location) 7 E. Eager Street

8. SEX Male

9. RACE White

10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married

11. DATE OF BIRTH 7/19/1892

12. AGE (in years last birthday) 74

13. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman

15. KIND OF BUSINESS OR INDUSTRY Retired

16. BIRTHPLACE (State or foreign country) Ireland

17. CITIZEN OF U.S.A.?

18. FATHER'S NAME Owens

19. MOTHER'S MAIDEN NAME Unknown

20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

21. SOCIAL SECURITY NO. 212-12-6785

22. INFORMANT John C. Murphy

23. ADDRESS Morchentele Trust Bldg. Balto. & Calvert Sts.

24. CAUSE OF DEATH

25. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic Heart Disease.

26. (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

29. MEDICAL CERTIFICATION

30. 19A. DATE OF OPERATION

31. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

32. 20A. AUTOPSY? (Yes or No) No

33. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

34. 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

35. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

36. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

37. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

38. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

39. 21F. HOW DID INJURY OCCUR?

40. 22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

41. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty

42. CHIEF MEDICAL EXAMINER ☐

43. M.D. ASSISTANT MEDICAL EXAMINER ☒

44. ASSOCIATE MEDICAL EXAMINER ☐

45. DATE SIGNED 3/14/67

46. 23A. BURIAL CREMATION, REMOVAL (Specify) Burial

47. 23B. DATE 3/16/67

48. 23C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery

49. 23D. LOCATION (City, town, or county) (State) Balto. Md.

50. 24A. DATE REC'D BY HEALTH DEPT.

51. 24B. NAME OF REGISTRAR

52. 24C. FUNERAL DIRECTOR Witzke Funeral Home

53. ADDRESS 4101 Edmondson Ave.

VS 151-REV. 1/67 MAR 16 1967 67 2583

WALLACE ROUGE

B-634

67 2584		BALTIMORE CITY HEALTH DEPARTMENT		67 2584	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		MILTON MELVIN BRADLEY		2. DATE AND HOUR PRONOUNCED DEAD March 11, 1967 8:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 123 S. Carlton Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH AUG 12, 1933	9. AGE (In years last birthday) 34	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHIREMAN		10B. KIND OF BUSINESS OR INDUSTRY SHIPPING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE THOMAS		14. MOTHER'S MAIDEN NAME LAURA BRADLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 0714		17. INFORMANT MAXINE MOSLEY 1521 W. FRANKLIN ST	
18. 00211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary tuberculosis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pulmonary emphysema					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/11/67			
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 3/17/67		23C. NAME of CEMETERY or CREMATORY MTCALVARY	
24A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		24B. NAME OF REGISTRAR Robert E. Fink		24C. FUNERAL DIRECTOR DONALD E. GLOVER 1701 N. PATTERSON PK. AVE	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2585		BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2585	
1. NAME OF DECEASED (Type or Print) Clyde Willi am Loper			2. DATE AND HOUR OF DEATH Mar. 14, 1967 10:50 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NJ B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bridgeton D. STREET ADDRESS (If rural, give location) 72 Laurel Heights Drive		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/17/08	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10B. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) NJ		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Loper			14. MOTHER'S MAIDEN NAME Edna Strang		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 142-09-7144	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 204.3 CAUSE OF DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) DUE TO Congestive heart failure (B) DUE TO Anemia (C) DUE TO Acute leukemia		INTERVAL BETWEEN ONSET AND DEATH Days Months Months
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Feb. 16 19 67 to Mar. 14 19 67 , that (I) (we) last saw the deceased alive on Mar. 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelczar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/15/67	
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, S.A. Surgeon (R) M.D.		23D. ADDRESS US PHS Hospital, Balto, 21211, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3-18-67	24C. NAME OF CEMETERY or CREMATORY TERWOOD MEMORIAL PARK	24D. LOCATION (City, town, or county) (State) BRIDGETON, NEW JERSEY		
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967	25B. NAME OF REGISTRAR Robert E. [Signature]	25C. FUNERAL DIRECTOR Wm Carl Bruck [Signature]		ADDRESS	

Michael E. Reagan

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2586

BIRTH NO. 67 2586

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MEADOWS DANNY L.

2. DATE AND HOUR OF DEATH

3-12-67

10:00A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2609 E. FAIRMOUNT AVENUE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

10-19-59

9. AGE (In years
lost birthday)

7

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JULIUS E. MEADOWS

14. MOTHER'S MAIDEN NAME

CAROLYN WILLIAMS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

No

17. INFORMANT

ADDRESS

White & White Funeral Home Richwood, W. Va.

18. 343X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Encephalitis

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/9 19 67 to 3/12 19 67,
that (I) (we) lost saw the deceased alive on 3/12 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kenneth L. Berns

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/12/67

23C. PHYSICIAN'S
NAME (Type)

DR. KENNETH I. BERN'S

M.D.

23D. ADDRESS

JHH.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/16/67

24C. NAME of CEMETERY or CREMATORY

Mountain View Cemetery

24D. LOCATION

(City, town, or county)

Richwood, W. Va.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 16 1967

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Wm Cook Brooks Inc 1217

ADDRESS

St Paul & Preston



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2587		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2587	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RUTH FITTIN		2. DATE AND HOUR OF DEATH March 14, 1967 9:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland 730 Ashburton St. Baltimore, Md. 21216		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 28-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207 D. STREET ADDRESS (If rural, give location) 4812 Norwood Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH December 10, 1893	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Mahffey			
14. MOTHER'S MAIDEN NAME Sarah Elizabeth Bolan		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. ???		17. INFORMANT ADDRESS Mr. Thomas B. Fittin, Same as # 4			
18. 561.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Electrolyte imbalance ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Intestinal obstruction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hiatus Hernia					
19A. DATE OF OPERATION 2/17/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Large bowel obstruction		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hiatus Hernia		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 27, 1967 to March 14, 1967 , that (I) (we) last saw the deceased alive on March 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 9:30 AM					
23A. SIGNATURE Manuel G. Fontanilla		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 14, 1967	
23C. PHYSICIAN'S NAME (Type) Manuel G. Fontanilla		23D. ADDRESS Lutheran Hospital of Maryland Baltimore, Md. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/67		24C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Towson, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. MAR 16 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND L. CLARKE

2. DATE AND HOUR PRONOUNCED DEAD

3-14-67

8:15 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

506 WOODBOURNE AVENUE - Amb. Crew #6

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

506 Woodbourne Avenue

21212

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

6-23-96

9. AGE (In years
last birthday)

XXX 70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?
U.S.A

13. FATHER'S NAME

Charles E. Clarke

14. MOTHER'S MAIDEN NAME

Lousie Craft

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW1

16. SOCIAL
SECURITY NO.

212-18-3893

17. INFORMANT

ADDRESS

Charles W. Clarke 419 Fawcett Street 21202

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-15-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-18-67

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Parkville

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 16 1967

Robert E. Fisher, M.D.

Wm. Cpok-Brooks Inc. 1217 St. Paul Street

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 08/24/05 BY 60321 JAV/STP

DATE 08/24/05 BY 60321 JAV/STP

11/11/05

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

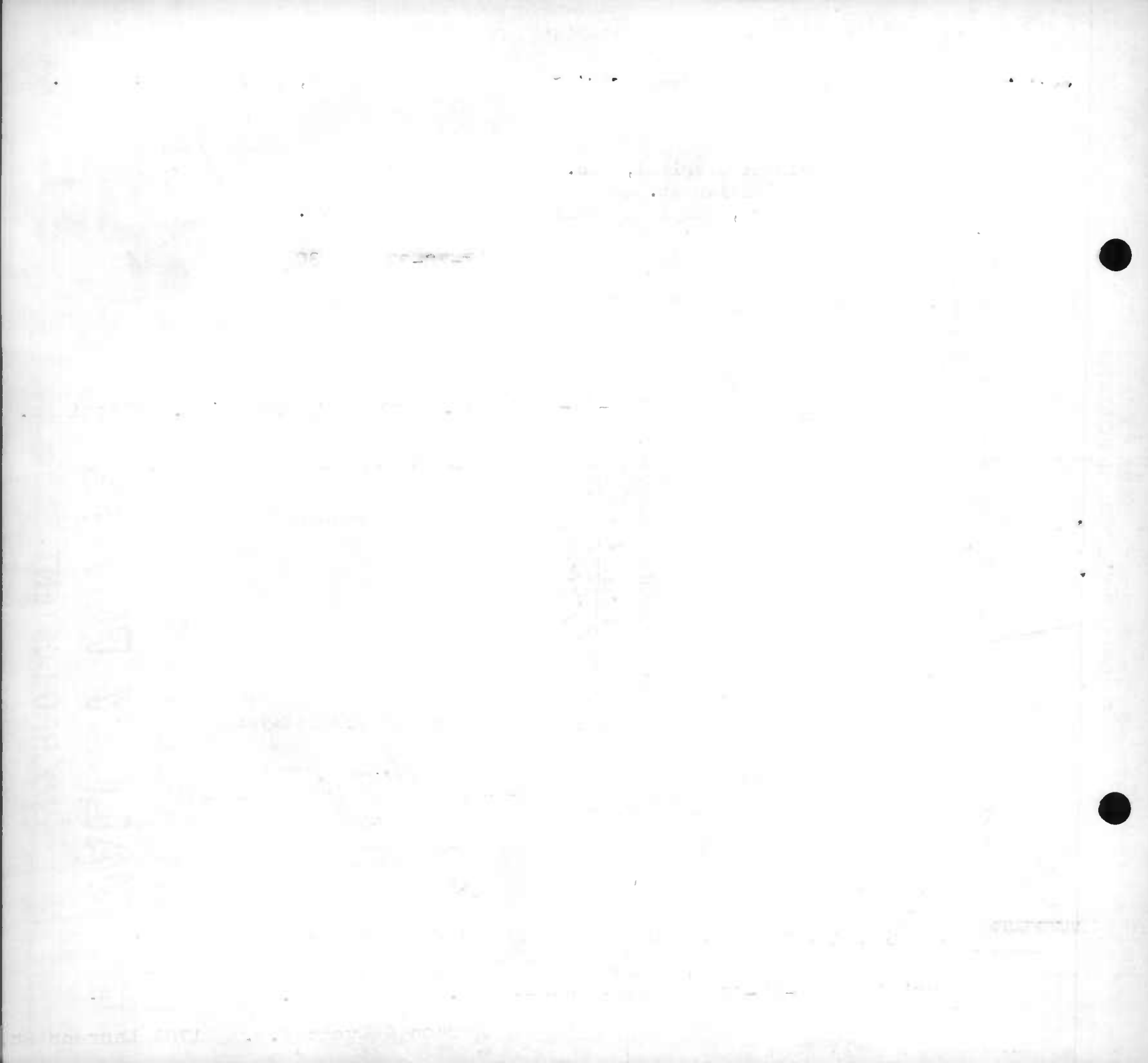
BIRTH NO. 67 2589		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2589	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Kathryn Belz		2. DATE AND HOUR OF DEATH MARCH 14 1967 7:45 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4th Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 27-44 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3407 Keene Ave			
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 6/27/82	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gottlieb Moenke		14. MOTHER'S MAIDEN NAME Mary Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs John M. Ryan	
18. 937X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Cerebrovascular Accident (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 20h	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3/13 1967 to 3/14 1967, that (I) last saw the deceased alive on 3/14 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Nate E. Watson, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/14/67	
23C. PHYSICIAN'S NAME (Type) NAT E. WATSON JR.		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE MAR 17 1967	24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEM		24D. LOCATION (City, town, or county) (State) 5501 FREDERICK RD MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR G. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS DIPPEL BROS INC 7110 BELAIR ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2590				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2590	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Robert Mashburn				2. DATE AND HOUR OF DEATH March 14, 1967 1:30 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217 </div> <div style="width: 50%;"> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) 17-02 Baltimore D. STREET ADDRESS (If rural, give location) 1343 Myrtle Ave. </div> </div>							
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 12-20-37	9. AGE (In years lost birthday) 30	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILL MASHBURN				14. MOTHER'S MAIDEN NAME ELLA LINDSEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 238-54-1381		17. INFORMANT Mrs. Martha Gibson		ADDRESS 4 S. Pulaski St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Acute toxemia DUE TO (B) extensive burn DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fremont and Lafayette 16-01			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 3 8 67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? House fire			
22. I certify that (I) (this hospital) attended the deceased from 3-8-67 to 3-14-67 that (I) (we) last saw the deceased alive on 3-14-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>S. Setasuban</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-14-67	
23C. PHYSICIAN'S NAME (Type) S. SETASUBAN				23D. ADDRESS PROVIDENT HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-17-67		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>W. J. F. F.</i>		25C. FUNERAL DIRECTOR Morton & Dyett F.H.		ADDRESS 1701 Laurens St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 2591	
BIRTH NO. 452 67 2591		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Williams, Irby Hardy</i>		2. DATE AND HOUR OF DEATH <i>3/14/67 5:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD.</i>		B. COUNTY	
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>1-30-1901</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years, last birthday) <i>66</i>		11. BIRTHPLACE (State or foreign country) <i>Blackstone, Virginia</i>	
13. FATHER'S NAME <i>Charles Williams</i>				14. MOTHER'S MAIDEN NAME <i>Martha Williams</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>216-10-3224</i>		17. INFORMANT <i>Mrs. Dorothy Williams</i>		ADDRESS <i>1503 Edmondson Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Lung Disease</i>				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>5 Cardiac Arrests</i>				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>2/16</i> 19 <i>67</i> to <i>3/14</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/14</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R. Moses</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robb Moses</i>				23D. ADDRESS <i>JHH</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-18-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Salsbery</i>		25C. FUNERAL DIRECTOR <i>Morton & Dyck F.H.</i>		ADDRESS <i>1701 Laurens St.</i>	



BALTIMORE CITY HEALTH DEPARTMENT

B-632 1 67 2592 BIRTH NO. 65-09367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered 67-2592

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		CYNTHIA BRIDGES		2. DATE AND HOUR PRONOUNCED DEAD March 10, 1967 8:10 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 1629 Ellsworth Street				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 8-07 D. STREET ADDRESS (If rural, give location) 1629 Ellsworth Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH 4/17/65	9. AGE (In years last birthday) 1	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME Luther Bridges			14. MOTHER'S MAIDEN NAME Jeanette Thorpe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Luther Bridges ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Cortical Atrophy. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty		M.D. Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE March 16/67		23C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem	
23D. LOCATION A.A. County, Md.		24A. DATE REC'D BY HEALTH DEPT. MAR 16 1967			
24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR John T. Elicker 1129 N. Caroline St			

VS 151-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2593		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2593	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) ARTHUR EDGAR ROBERTSON			2. DATE AND HOUR OF DEATH 3/10/67 9⁵⁵a M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7329 HARTFORD ROAD 27-05		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME ADAM ROBERTSON			14. MOTHER'S MAIDEN NAME ANNIE JONES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Acute bronchopneumonia DUE TO Acute gastric ulcer with reg. (B) Laennec's Cirrhosis DUE TO (C) Severe arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH AT Nipolito, N.D.		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1 19 67 to March 10 19 67 , that (I) (we) last saw the deceased alive on March 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nieva G. Valle				23B. DATE SIGNED March 10, 1967	
23C. PHYSICIAN'S NAME (Type) NIEVA G. VALLE				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-13-67		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

UNION MEMORIAL HOSPITAL
Baltimore
4324 HARBOR ROAD

APRIL 1942
Baltimore
APRIL 1942
Baltimore

USA

Write to the
Director of the
Bureau of
Investigation
Washington, D.C.

yes

NEVA G. VALLE
Director of the
Bureau of
Investigation

213-2

March 10 - 1942
Bureau of
Investigation

Director of the
Bureau of
Investigation

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2594				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2594	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mabel M. Fertig				2. DATE AND HOUR OF DEATH March 14, 1967 2:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 303 Thornhill Road Baltimore, Maryland 21212				A. STATE B. COUNTY Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-12			
				D. STREET ADDRESS (If rural, give location) 303 Thornhill Road 21212			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 3, 1890	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Matthew Meyer				14. MOTHER'S MAIDEN NAME Emma Elizabeth Gross			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Evelyn Kabernagel, Jr.		ADDRESS same address	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) Cerebral Hemorrhage (B) Hypertension (C) Arterio-sclerosis 1/2-1 hr Gradual onset 10-15 yr			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) -		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 1936 to March 14 1967, that (I) (we) last saw the deceased alive on Jan 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J.H. Hardy				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-15-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. 1403 Park Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/1967		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS Datto, Ind. North Pa.	



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2595

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LAURENCE SEIBERT		2. DATE AND HOUR PRONOUNCED DEAD 3-14-67 6:55 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2656 PENNSYLVANIA AVENUE - Sgt. W. Ritter		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 2700 Mathews Street 21218 D. STREET ADDRESS (If rural, give location)	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 7, 1882
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 83
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lawrence Seibert		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 212-12-9249 A	
17. INFORMANT Mrs. Frances Lee Seibert same address		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/17/1967	
23C. NAME OF CEMETERY or CREMATORY Western Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		24B. NAME OF REGISTRAR R. B. E. Fisher, M.D.	
24C. FUNERAL DIRECTOR Wm. Fisher & Sons with L.P.		ADDRESS Baltimore, Md.	

WALLACEY PROJE

WALLACEY PROJE

WALLACEY PROJE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2596		CERTIFICATE OF DEATH		Registered No. 67 2596	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
WILLIAM GEARY				2-10-67 5:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
94 BALTO. EYE, EAR AND THROAT HOSP. 1214 EUTAW PLACE, BALTO. MD. 21217				Md.					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		19-02			
				D. STREET ADDRESS (If rural, give location)					
				226 N. Gilmore St.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
M	N	Never Married	1895 May 15	71 52					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Unknown					Virginia		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
John Geary			Unknown: Evans, Jennie						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			217 07 2297		Chart and Margaret Chester 2533 Pk. Hgts. Terrace (Sister)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Cardiac arrest & Cardiac resp. failure (B) 1) Senile epistaxis (C) 2) ASCVD					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
3-2/8/67		Senile Epistaxis		Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
no		N/A		N/A					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Feb 5 1967 to Feb 10 1967, that (I) (we) last saw the deceased alive on Feb 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
Thomas M. Demme						Feb 10, 1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION			
		3-16-67		ANATOMIC BOARD OF MARYLAND		JOHNS HOPKINS MEDICAL SCHOOL, MORTUARY SERVICE - BCHD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 16 1967		Robert E. Garbino							

3-1003

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2597		REGISTERED NO. 67 2597	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) GERHARDT, RUDOLF				2. DATE AND HOUR OF DEATH 14 MARCH 67 9 50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP.				A. STATE MD			
				B. COUNTY BALTO. CO.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN ARM				53-00			
D. STREET ADDRESS (If rural, give location) Box 418 - NOTCH CLIFF ROAD							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 02-25-82	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAINER (HORSE)		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unk		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ACIDOSIS				INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PULMONARY EMPHYSEMA							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CO₂ NARCOSIS, ASPIRATION PNEUMONIA (CLEARED)							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 8 MARCH 1967 to 14 MARCH 1967 , that (H) (we) last saw the deceased alive on 14 MARCH 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sidney E. Kinkley				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 14 MARCH 67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-15-67		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR P. E. E. E.		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD			

3-12-67

Arthur E. Kibbey

March 12

63

March 12

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-04866 67 2598		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2598	
M.E. CASE NO.		CERTIFICATE OF DEATH		2	
1. NAME OF DECEASED (Type or Print) Baby Boy Lawson		2. DATE AND HOUR OF DEATH 3-9-67 @ 12:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Md. Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1610 N. Hulton St #16			
5. SEX Male	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3/1/67	9. AGE (In years lost birthday) Newborn	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 17 min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Univ. Hospital	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Sidney Lawson		14. MOTHER'S MAIDEN NAME Barbara Telle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 75-0X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Congenital Anemophaly DUE TO (B) Complicated pregnancy: Pre-eclampsia DUE TO (C) Hydramnios		INTERVAL BETWEEN ONSET AND DEATH 17 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE P. Setasuban		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3.9.67	
23C. PHYSICIAN'S NAME (Type) P. SETASUBAN		23D. ADDRESS 1514 DIVISION ST. BALTO. MD. # 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) 3-14-67		24B. DATE		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967			
25B. NAME OF REGISTRAR John S. Talley		25C. FUNERAL DIRECTOR ADDRESS 2 MORTUARY SERVICE - BCHD			

Report of the

Committee on

Education

Washington

1910

12-11-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-01039 67 2599		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2599 4	
M.E. CASE NO.				1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print) BABY GIRL SPENCER				2. DATE AND HOUR OF DEATH 2/27/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY BALTO. CITY	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
8. DATE OF BIRTH 2/27/67		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days 1 20	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN T. SPENCER		14. MOTHER'S MAIDEN NAME ELIZABETH S. PEACE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTHER SAME AS ABOVE	
18. 776 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Immaturity DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 20 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0-		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 2/27/67 11:00 AM to 2/27/67 12:30 PM, that (I) (we) lost saw the deceased alive on 2/27/67 12:30 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. Reroma		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2/27/67	
23C. PHYSICIAN'S NAME (Type) FLORAHAYDA S. REROMA		23D. ADDRESS UNIVERSITY OF HOSPITAL AND			
24A. BURIAL CREMATION, REMOVAL (Specify) 3-14-67		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county) BALTO. (State) MD		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR Robert E. J. J. J.	
25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR		25E. FUNERAL DIRECTOR	
JOHNS HOPKINS MEDICAL SCHOOL		MORTUARY SERVICE - BCHD			

3-14-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 2600		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2600	
BIRTH NO. 67-04031		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARVIN, BABY BOY		2. DATE AND HOUR OF DEATH 3/1/67 1:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) X D. STREET ADDRESS (If rural, give location) 25-33 2630 Maesbury Ct #30	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University		(If not in hospital or institution, give street address or location)		5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/25/67 9. AGE (In years last birthday) 4 10. Under 1 Yr. Months 4 11. Under 24 Hrs. Min.	
13. FATHER'S NAME Daniel Harvin		14. MOTHER'S MAIDEN NAME Essie Mae Burgess		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT CHART ADDRESS	
18. 754.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Transposition of great vessels) Birth DUE TO With Patent Ductus & IVSD (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/25 19 67 to 3/1 19 67, that (I) (we) last saw the deceased alive on 3/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Keith E. Luddy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/1/67	
23C. PHYSICIAN'S NAME (Type) RUTH E. LUDDY		M.D. 23D. ADDRESS University Maryland		24. LOCATION (City, town, or county) (State)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-14-67		24C. NAME OF CEMETERY OR CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

3-14-05

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-03227 2601		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2601 ✓	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY BOY HILL A</u>		2. DATE AND HOUR OF DEATH <u>3/4/67</u> <u>2:15 A.M.</u>	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>2208 Norfolk Ave</u>		25-33 Ave	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>2/14/67</u>	9. AGE (In years last birthday) <u>17</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FREDERICK HILL</u>		14. MOTHER'S MAIDEN NAME <u>Loretta</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ELLIS T. TOKAR M.D. Univ Hosp</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Hemorrhage</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>17 DAYS</u> <u>1 day</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>(Prematurity)</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/14/67</u> 19 to <u>3/4/67</u> 19, that (I) (we) last saw the deceased alive on <u>3/4/67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ellis T. Tokar</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/4/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ELLIS T. TOKAR M.D.</u>		23D. ADDRESS <u>UNIV. HOSP</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>City Disposal</u>		24B. DATE <u>3-14-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltman</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		25D. ADDRESS			

3-14-71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 2602					CERTIFICATE OF DEATH					
M.E. CASE NO. 67-005572					Registered No. 67 2602					
1. NAME OF DECEASED (Type or Print) MAE SHIRLEY JOHNSON					2. DATE AND HOUR OF DEATH 2-26-67 1 8:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND UNIVERSITY HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 111 N. CAREY ST.					
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 2-17-67	9. AGE (In years last birthday) 9	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME RUFUS JOHNSON				14. MOTHER'S MAIDEN NAME MAGGIE MAE ANDERSON						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT CHART		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS; if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Respiratory arrested DUE TO (B) Poss Cyanotic Cong. Heart Dis. DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 2-27 19 67 to 2-28 19 67, that (1) (we) lost saw the deceased alive on 2-28- 19 67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Mary Beth Keeler					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2-28-67			
23C. PHYSICIAN'S NAME (Type) MARY BETH KEELER					23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) CITY		24B. DATE 3-14-67		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) AND (State) JOHNS HOPKINS MEDICAL SCHOOL				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS MORTUARY SERVICE - BCHD				

Administrative

2-14-61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2603		BALTIMORE CITY HEALTH DEPT.		Registered No. 67 2603	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) TOMBLIN, BABY BOY		2. DATE AND HOUR OF DEATH MARCH 8, 1967 10⁴⁵ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL 35		A. STATE MD. - B. COUNTY CITY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - #2 3-02			
		D. STREET ADDRESS (If rural, give location) 902 FAWN ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 3-8-67	9. AGE (In years last birthday) NO	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. 05
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME IRA PAUL TOMBLIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME LINDA ANN FERRIS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardio - Respiratory arrest		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Immaturity			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO			
19A. DATE OF OPERATION 3-8-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED premature rupture of membrane		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 10:40 PM 3-8-67 to 10:44 PM 3-8-67	
22. I certify that (I) (this hospital) attended the deceased from 10:40 PM 3-8-67 to 10:44 PM 3-8-67 and that (I) (we) last saw the deceased alive on 3-8-67 and that (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louise T. Swadlow		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-9-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-13-67		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR DR. E. J. ...		25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

Good road

Good road & house

W 2nd

1st floor

no

no - 2nd

2nd floor

2nd floor

W 2nd

1st floor

1st floor

2nd

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2604		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Baby of Ramona Wilburn		2-26-67 12:45 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Maryland	
39 Provident Hospital, Inc.		Baltimore, Maryland 21217		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				510 N. Pearl Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Negro		2-26-67	Newborn	1 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None		None		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Anthony Wilson			Ramona J. Wilburn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Ramona Wilburn 510 Pearl Street	
18. 762.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		1:50 hr	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-26-67 19 to 2-27-67 19, that (I) (we) last saw the deceased alive on 2-27-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
P. Setesauban				2-27-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Setesauban		1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		3-16-67		JOHNS HOPKINS MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 16 1967		R. C. E. E. E. E.		MORTUARY SERVICE - BCHD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2605	
BIRTH NO. 67-03933		2605		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Boy of Elizabeth Hurley		2. DATE AND HOUR OF DEATH 3-2-67 9:40P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY Calvert Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Chesapeake Beach, Maryland			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2-28-67	9. AGE (In years last birthday) Newborns	If Under 1 Yr. Months: 0 Yrs: 2 If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Hurley		14. MOTHER'S MAIDEN NAME Elizabeth Hawkins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 773.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory disease DUE TO (B) No Congenital heart disease DUE TO (C) No intracranial injury		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-28-67 19 to 3-2-67 19, that (I) (we) last saw the deceased alive on 3-2-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mahmoodian		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-6-67	
23C. PHYSICIAN'S NAME (Type) Mahmoodian		23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) 3-18-67		24B. DATE		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967			
25B. NAME OF REGISTRAR D. E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE BCHD			

2-81-8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

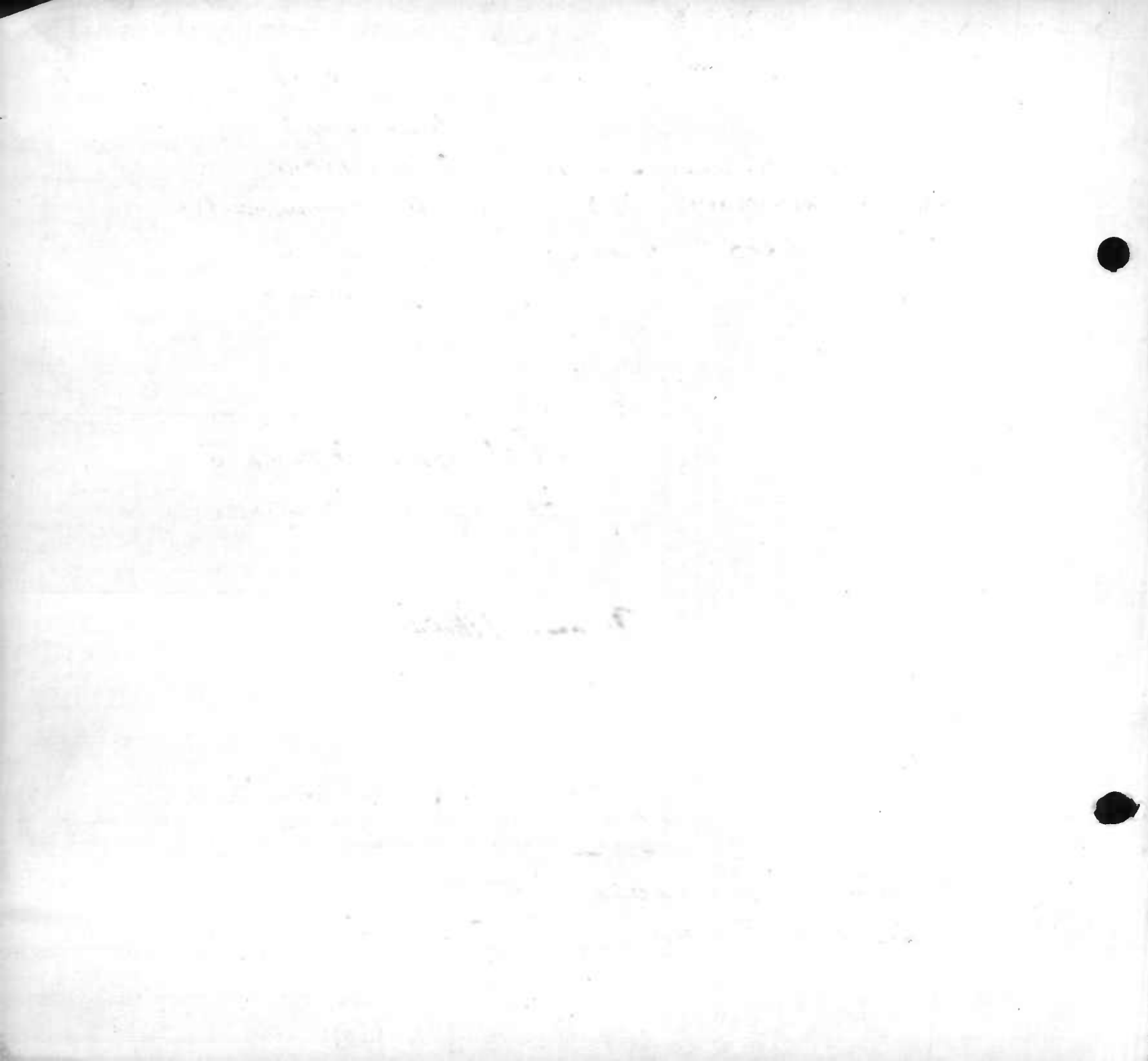
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 2606	
BIRTH NO. 67-2606				M.E. CASE NO. 67-2606			
1. NAME OF DECEASED (Type or Print) Baby of Alice Foster				2. DATE AND HOUR OF DEATH March 10, 1967 2:50 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217 (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
5. SEX Male				6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) Newborn	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA		If Under 1 Yr. Months Days Hours Min.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Alice Foster			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Prematurity (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage Atelectasis neonatorum				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-8-67 to 3-10-67 and that (I) (we) last saw the deceased alive on 3-10-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. G. Mercado				23B. DATE SIGNED 3-13-67			
23C. PHYSICIAN'S NAME (Type) M. G. MERCADO				23D. ADDRESS ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) 3-16-67				24B. DATE		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 16 1967				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	

3-11-8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2607				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2607	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) HELEN ESTES BAKER		2. DATE AND HOUR OF DEATH 3/10/67 8⁰⁰ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
00 5217 KENILWORTH AVE		BALTIMORE, MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 27-10	
D. STREET ADDRESS (If rural, give location)				5217 KENILWORTH AVE			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH SEPT. 7, 1906	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
TEACHER- SOCIAL WORKER				SUFFOLK, VIRGINIA		U.S.	
13. FATHER'S NAME JAMES A. ESTES				14. MOTHER'S MAIDEN NAME MARY BRETT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 365-20-9705		17. INFORMANT PERCY H. BAKER		ADDRESS 5217 KENILWORTH AVE BALTIMORE 12, MD	
18. 1966-91				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO OSTEOGENIC SARCOMA C			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO GENERALIZED METASTASES			
ANTECEDENT CAUSES				(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pulmonary Fibrosis			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 19 66 to MARCH 10 19 67 , that (I) (we) last saw the deceased alive on MARCH 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE GILBERT L. BANFIELD				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/10/67	
23C. PHYSICIAN'S NAME (Type) GILBERT L. BANFIELD				23D. ADDRESS 722 N. Fulton Ave Balt, Md.			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 3-10-67		24C. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE		ADDRESS BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-15756 2608				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2608	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Algie Kane				2. DATE AND HOUR OF DEATH 3/6/67 7:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 913 Somerset Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Child	8. DATE OF BIRTH 7/1/65	9. AGE (In years last birthday) 1	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Charles Kane				
14. MOTHER'S MAIDEN NAME Helen Hutchings			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT Helen Kane 913 Somerset St				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 493X1 Pneumonia			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Patient arrived DOA 19 19 , that (I) (we) lost saw the deceased alive on 19 and that in (my) <u>aur</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.							
23A. SIGNATURE A. Baghdassarian				23B. DATE SIGNED 3/7/67			
23C. PHYSICIAN'S NAME (Type) A. BAGHDASSARIAN				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/11/67		24C. NAME OF CEMETERY or CREMATORY Bald Natl Cem		24D. LOCATION (City, town, or county) (State) 5501 Federal Ave	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William E. Elchman 1129 N. Capital St			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 67 2609					
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 2609</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED Holmes Harold H Wrenn</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 3/6/67 7:40 P.M.</p> </div> </div>										
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 1.2em;">44 Union Memorial Hospital</p>					<p>4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)</p> <p>A. STATE Md B. COUNTY Baltimore City</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 40 Warrenton Road</p>					
<p>5. SEX M</p>		<p>6. RACE Caucasian</p>		<p>7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married</p>		<p>8. DATE OF BIRTH 04/27/87</p>		<p>9. AGE (In years last birthday) 79</p>		
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p>					<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Virginia</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Aurelius Wrenn</p>					<p>14. MOTHER'S MAIDEN NAME Mary Middleton Woodward</p>					
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>					<p>16. SOCIAL SECURITY NO. 212-32-0755A</p>		<p>17. INFORMANT ADDRESS Dr. Ridge way Trimble</p>			
<p>18. 13-18 CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 35%;"> <p>(A) Cancer of Stomach DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p> </div> </div> <p>INTERVAL BETWEEN ONSET AND DEATH 5 Months</p>										
<p>19A. DATE OF OPERATION 2/22/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent Cancer Stomach 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>										
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>				
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>				<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>				
<p>22. I certify that (I) (this hospital) attended the deceased from 2/11 1967 to 3/6 1967, that (I) (we) last saw the deceased alive on 3/6 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.</p>										
<p>23A. SIGNATURE Charles H. Classen, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>								<p>23B. DATE SIGNED 3/6/67</p>		
<p>23C. PHYSICIAN'S NAME (Type) CHARLES H. CLASSEN, JR. M.D.</p>								<p>23D. ADDRESS THE UNION MEMORIAL HOSPITAL</p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 3-7-67</p>		<p>24B. DATE</p>		<p>24C. NAME OF CEMETERY or CREMATORY ANA</p>		<p>24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND</p>				
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher</p>		<p>25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE BCHD</p>						

Hospital -
H. W. W. W.

3/6/67

Mr Baltimore City

Union Memorial Hospital

Baltimore

10 Waverston Road

M. Carson married 04/2/67 29

Noticed

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USA

Are/ins When Mary Middleton Woodland

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3/22/67 Recurrent Cancer Stomach

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Charles M. M. M.

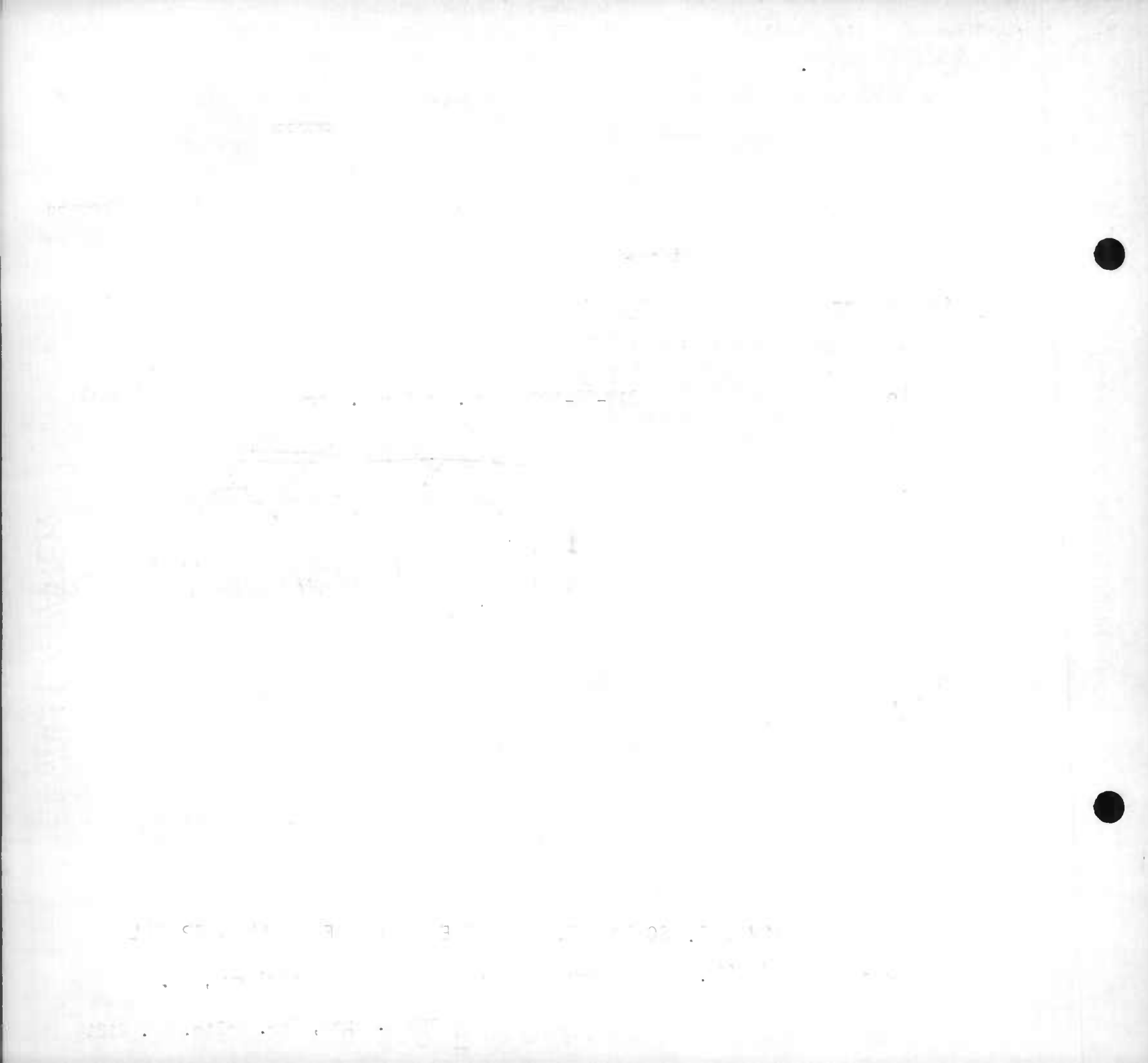
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

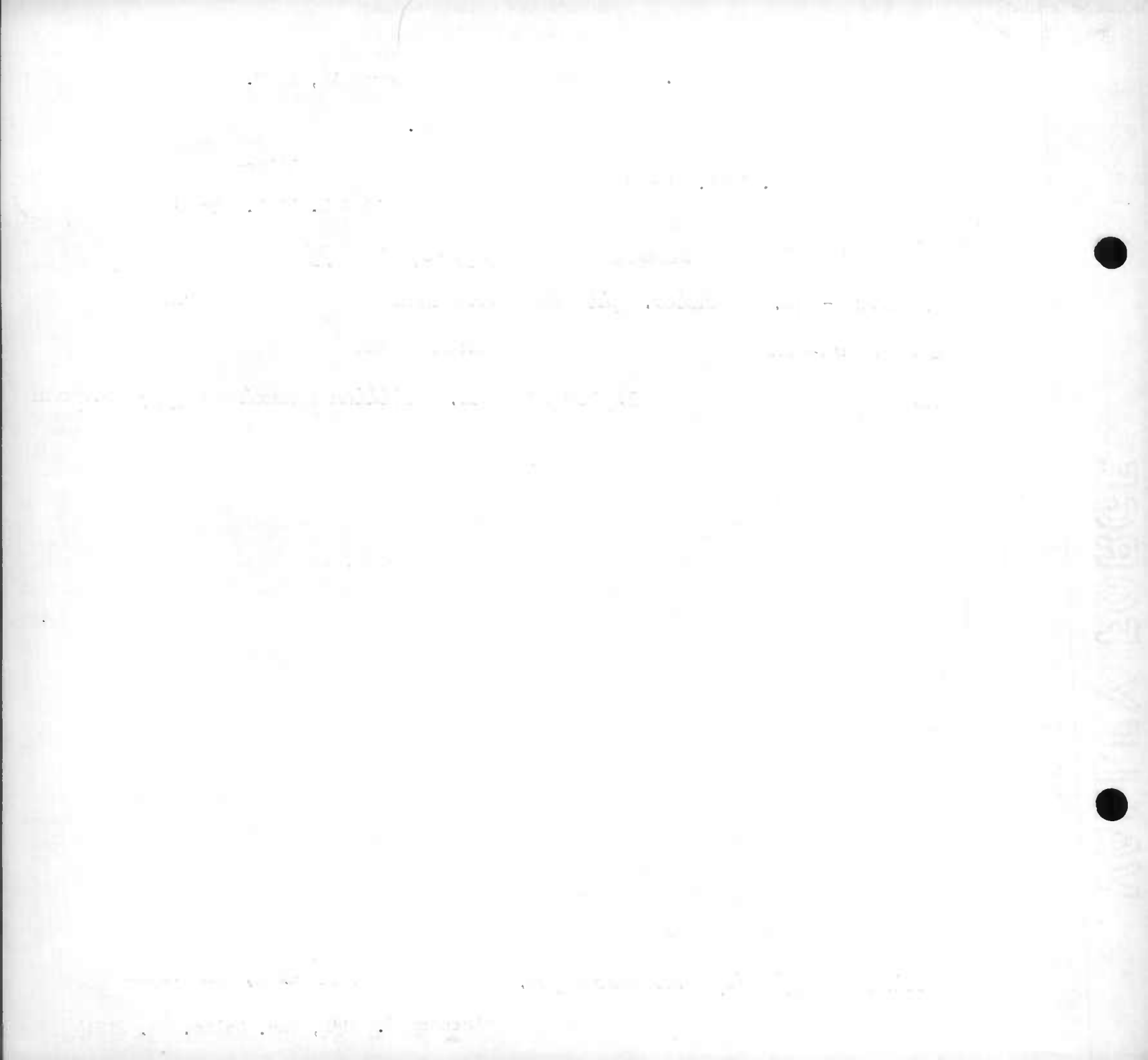
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2610		CERTIFICATE OF DEATH		67 2610	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Richard Schverholz.			2. DATE AND HOUR OF DEATH 3/15/67 - 1 7:15 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2103 Lake Montebello Terrace		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/11/74	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: Hours: Min. 1 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) Lithographer Retired		10B. KIND OF BUSINESS OR INDUSTRY Maryland	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Schverholz			14. MOTHER'S MAIDEN NAME Julia Weikert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 218-22-1094A	17. INFORMANT Mrs. Lester H. Kern		ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO 1) C.H.F. (B) DUE TO 2) Statute post 9 days synapubric (C) DUE TO 3) nephrosclerosis. 1) Myocardial Infarction 2) Sudden Synapubric Death		INTERVAL BETWEEN ONSET AND DEATH 9 days	
19A. DATE OF OPERATION 3/5/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bypass Prostetic Hypertrophy		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 3/6/67 19 to 3/15 19 67, that (B) (we) last saw the deceased alive on 3/15 19 67 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE David S. Schwartz			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/15/67
23C. PHYSICIAN'S NAME (Type) DAVID S. SCHWARTZ, M.D.			23D. ADDRESS THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/67		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE (State) Md.		24F. ADDRESS (Address) 2103 Lake Montebello Terrace	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 67 2611					CERTIFICATE OF DEATH					Registered No. 67 2611									
1. NAME OF DECEASED (Type or Print) FRANK P. COLEMAN										2. DATE AND HOUR OF DEATH March 16, 1967. ✓ 6 0. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1622 E. 31st. Street										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1622 E. 31st. Street									
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 4/5/1891		9. AGE (In years last birthday) 75		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Detective-Ret.					10B. KIND OF BUSINESS OR INDUSTRY Balto. City PD					11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Frank Coleman					14. MOTHER'S MAIDEN NAME Sarah Weber														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. 213282322		17. INFORMANT Mrs. Lillian Beauchamp					ADDRESS 4539 Harford							
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) Carcinoma of the lung DUE TO with widespread metastasis (B) Diabetes Mellitus DUE TO 1950 (C) Hypertension Arteriosclerotic Cardiovascular Disease 1950					INTERVAL BETWEEN ONSET AND DEATH Aug. 1966 1950 1950				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None																			
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 1950 to March 16 19 67 , that (I) (we) last saw the deceased alive on March 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Wilfred H. Townshend M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED 3-16-67									
23C. PHYSICIAN'S NAME (Type) Wilfred H. Townshend					23D. ADDRESS 14 E. Eager Street - 21200.														
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3/20/67		24C. NAME of CEMETERY or CREMATORY Parkwood Cem.					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland									
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967					25B. NAME OF REGISTRAR R. E. Eager					25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214									



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2612	
BIRTH NO. 67 2612		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DILL, MRS. ADDIE M.		2. DATE AND HOUR OF DEATH 3-15-67 1145 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21212 27-12 D. STREET ADDRESS (If rural, give location) 314 E. Meade Ave		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5-9-91	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William R. Cunningham			14. MOTHER'S MAIDEN NAME Addie Foos		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-48-9743	17. INFORMANT Mr. Harry C. Dill		ADDRESS (Same)
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Subarachnoid Hemorrhage DUE TO (B) Aneurysm - Middle cerebral DUE TO (C) Acute Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk
19A. DATE OF OPERATION 3-8-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Atherosclerosis		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-15 3-15 19 67 to 3-15 19 67 , that (I) (was) last saw the deceased alive on 3-15 19 67 and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE William T. Mason M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3-15-67	
23C. PHYSICIAN'S NAME (Type) William T. Mason		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/18/67	24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

MANHATTAN
BARTON
34 E. Avenue Ave

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Ande Highway - Street

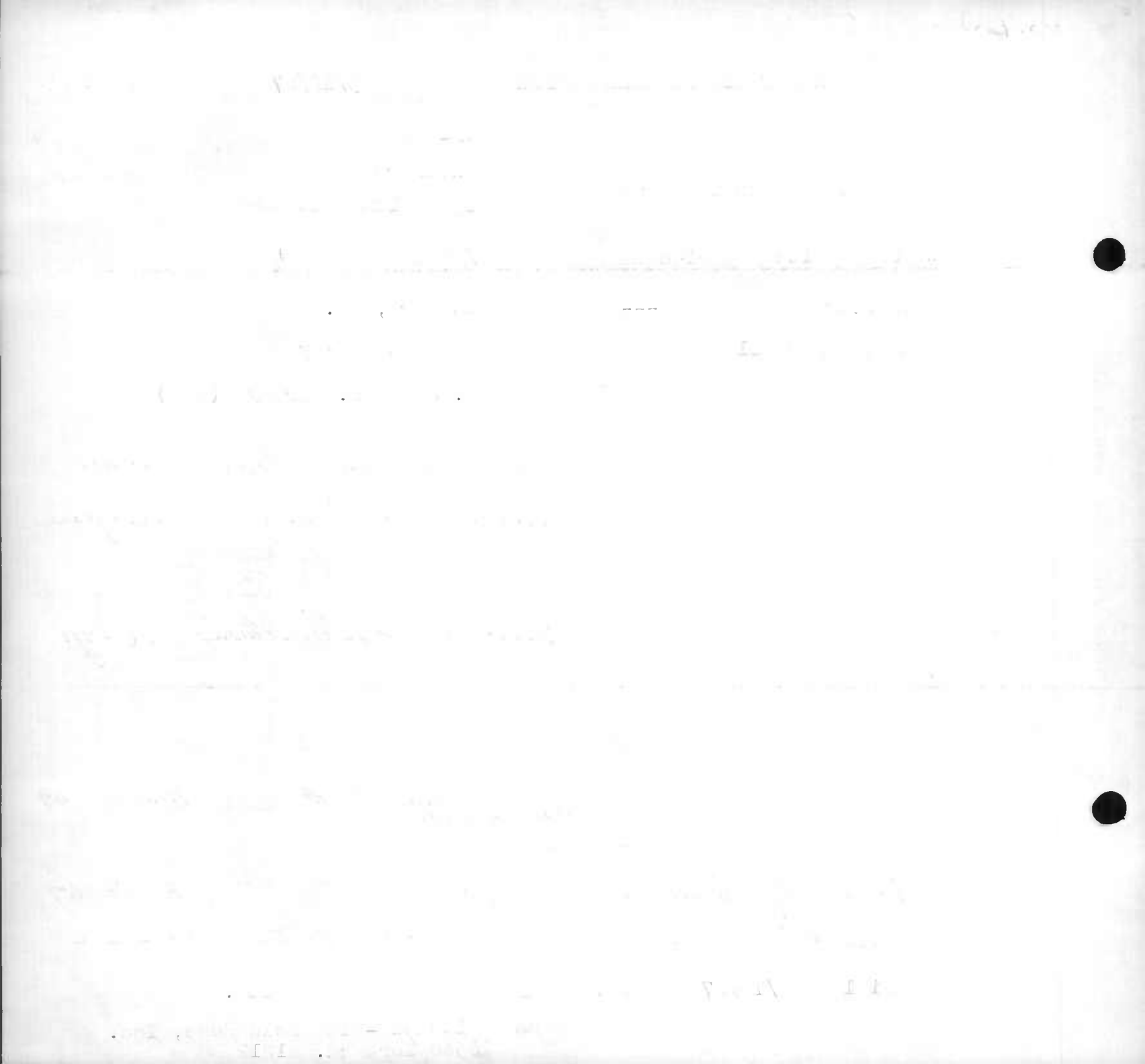
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
M-610 67 2613					BIRTH NO. 67 2613				
CERTIFICATE OF DEATH					Registered No. 67 2613				
1. NAME OF DECEASED (Type or Print) ANASTATIA PARRELL MURPHY					2. DATE AND HOUR OF DEATH 3/10/67 6:15 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Edgewood Nursing Home					4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-38 D. STREET ADDRESS (If rural, give location) 1542 Gleneagle Road				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 9/22/1882	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY ---			11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Parrell					14. MOTHER'S MAIDEN NAME Margaret Conway				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. James P. Murphy (Son)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Carcinoma of bone DUE TO (B) Carcinoma, breast DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH 6 mos 10 yrs 10+ yrs.	
					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Aug 1958 to Mar 10 1967 , that (I) (we) last saw the deceased alive on Mar 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Frederick J. Vollmer					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-13-67		
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER					23D. ADDRESS M.D. 6100 YORK RD. BALTIMORE, MD 21212				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/67		24C. NAME of CEMETERY or CREMATORY Cathedral Ce m		24D. LOCATION (City, town, or county) (State) Balto.			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967			25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 3560 York Rd. 21212				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2614		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2614	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Martha C. Pitts		2. DATE AND HOUR OF DEATH March 14, 1967		10:30 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 460 Tubman Court		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 460 Tubman Court			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Dec. 2, 1876	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joeeph Pitt		14. MOTHER'S MAIDEN NAME Stassberry	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS George E. Pitt 460 Tubman Court	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY Occlusion - 2 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROTIC C-V DISEASE 20 years		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 20 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-15 1963 to -3-14 1967 , that (I) (we) last saw the deceased alive on 3-14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Norman R. Kleiman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/15/67	
23C. PHYSICIAN'S NAME (Type) NORMAN R KLEIMAN		23D. ADDRESS 3803 EDMONDSON AVE 3/15/67			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-67		24C. NAME of CEMETERY or CREMATORY Aberdeen Cemetery	
24D. LOCATION (City, town, or county) (State) Aberdeen, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1967		25B. NAME OF REGISTRAR James G. Hensley		25C. FUNERAL DIRECTOR ADDRESS 718 W. Biddle St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2615	
BIRTH NO. 67 2615		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CARRICO, GRADY BOYD		2. DATE AND HOUR OF DEATH 3-14-67 3:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL <i>40</i>		A. STATE MD B. COUNTY Balt. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1830 WOODSIDE AVE. <i>53-00</i>			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-29-15	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENCILER		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME BOYD		14. MOTHER'S MAIDEN NAME ETTA B KELL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 227 05 4318		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 581.01 BLEEDING ESOPHAGEAL VARICES CIRRHOSIS of LIVER		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN (PROB. 7 DAYS)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 5 19 67 to MARCH 14 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 14 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.					
23A. SIGNATURE Ralph V Ramirez		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-14-67	
23C. PHYSICIAN'S NAME (Type) RALPH V RAMIREZ <i>Ralph Ramirez</i>		23D. ADDRESS 3350 WICKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St.	

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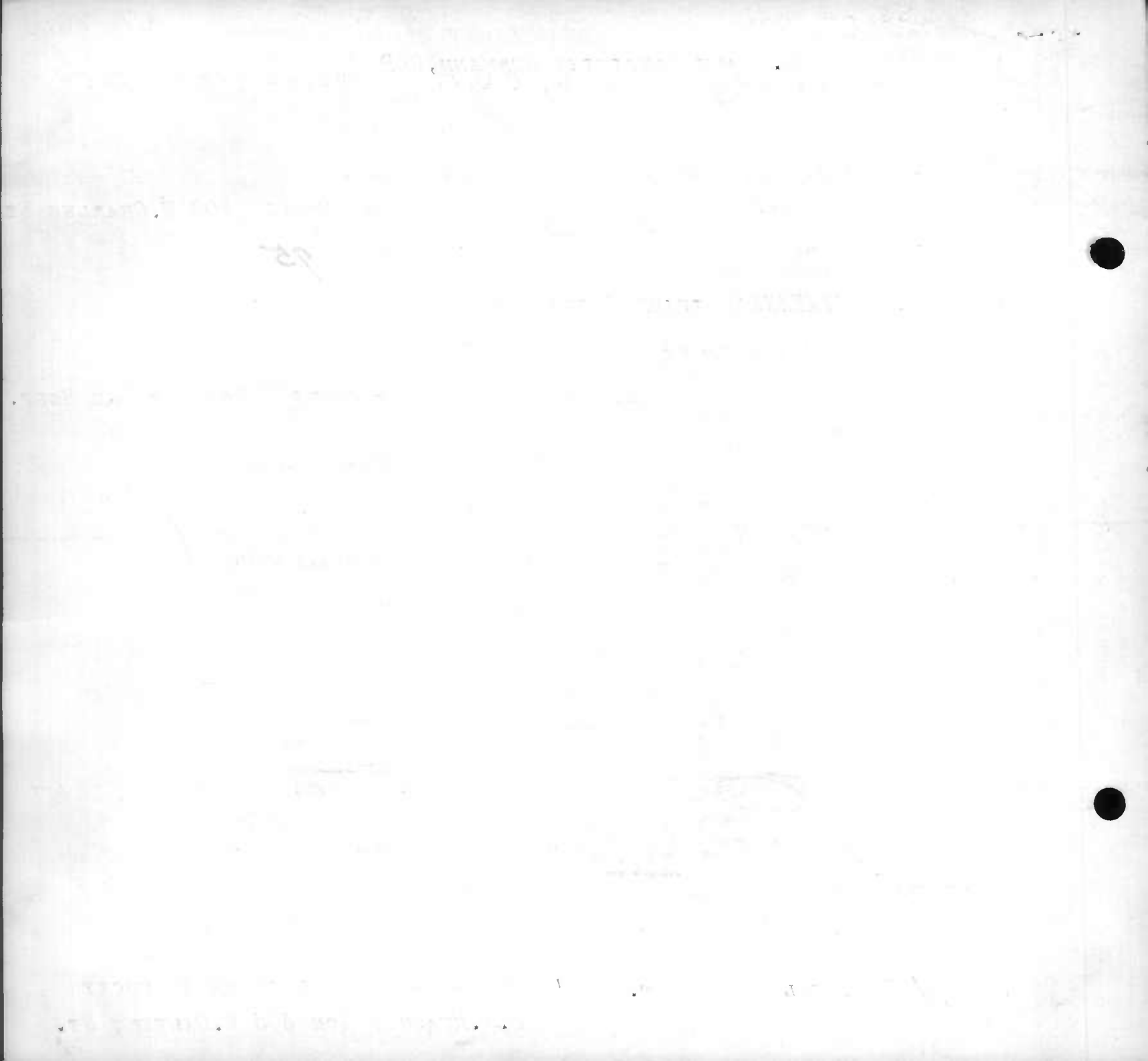
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-655 67 2616		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2616	
BIRTH NO.		M.E. CASE NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) SR. MARY CRUCIFIXA GERMAN, CDP		2. NAME OF DECEASED (Type or Print) SISTER MARY CRUCIFIXA, C.D.P.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. SEX F		6. RACE N	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 12/21/91	
D. STREET ADDRESS (If rural, give location) CARDINAL HOUSE 408 N. CHARLES ST		9. AGE (In years lost birthday) 75		10. AGE (In years lost birthday) 75	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME WM M. GERMAN	
14. MOTHER'S MAIDEN NAME ROSA SPILLEN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-54-1361	
17. INFORMANT CHART		18. ADDRESS BON SECOURS HOSP.		19. ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOCLAR NEPHROSCLEROSIS (A) DUE TO HACVD (B) DUE TO GENERALIZED ARTERIOSCLEROSIS (C) DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH MONTHS		20. INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
24. MEDICAL CERTIFICATION 19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from FEB 6 19 67 to MARCH 11 19 67 .		23. I certify that (I) (we) last saw the deceased alive on MARCH 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		24. SIGNATURE Ramon Roig MD M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
25. DATE SIGNED 3/11/67		26. PHYSICIAN'S NAME (Type) RAMON ROIG MD		27. ADDRESS 101 W READ ST BALTO	
28. BURIAL CREMATION, REMOVAL (Specify) BURIAL		29. DATE 3/15/67		30. NAME OF CEMETERY or CREMATORY ST. ANN'S CEMETERY	
31. LOCATION (City, town, or county) (State) MELBOURNE KENTUCKY		32. DATE REC'D BY HEALTH DEPT. MAR 17 1967		33. NAME OF REGISTRAR H.W. MEARS & SON	
34. FUNERAL DIRECTOR ADDRESS 805 N. CALVERT ST.		35. FUNERAL DIRECTOR ADDRESS		36. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		I. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MERCY HOSPITAL	
2. DATE AND HOUR OF DEATH 10:23 PM 3/12/67		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) BALTIMORE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD		D. STREET ADDRESS (If rural, give location) 519 OVERBROOK RD		5. SEX M		6. RACE W	
7. AGE (in years) 76		8. DATE OF BIRTH 8/13/1890		9. AGE (in years) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN KEATING		14. MOTHER'S MAIDEN NAME MARY ANNE CONNOR		15. Was Deceased Ever in U. S. Armed Forces of Service? (If yes, give war or dates of service) (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT THOMAS KEATING		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I		ANTECEDENT CAUSES (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death)		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 19B. CONDITION OR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN ESTABLISHING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNOCCURRING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/6/67 to 3/12/67 and that (1) (we) lost saw the deceased alive on 3/12/67 and that in (my) (our) opinion death occurred on the date 3/12/67		23A. SIGNATURE F H COST		23B. DATE SIGNED 3/11/67		23C. PHYSICIAN'S NAME (Type) F H COST		23D. ADDRESS MERCY HOSPITAL		24A. BURIAL CREMATION 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS					

Official M.D.
CHIEF OR ASST. MEDICAL EXAMINER
NOT MEDICAL EXAMINER'S CASE

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
5:17 AM 3/12/67
Registered No. 67-2617

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2618	
BIRTH NO. 00 67 2618		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) FLORENCE MAVER		MARCH 13, 1967 1 8 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 5962 GREEN MEADOW PARKWAY		A. STATE MARYLAND B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 5962 GREEN MEADOW PARKWAY	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE (Domestic)		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) BROOKLYN, NEW YORK
13. FATHER'S NAME SAMUEL MAVER		14. MOTHER'S MAIDEN NAME FRANCES HAHNESAND	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. MAURICE KAPLAN, 3715 STRATHMORE AVENUE		ADDRESS	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-Respiratory Failure Cerebral Vascular Hemorrhage Hypertensive - Art & VHD Blindness		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1940 to March 13 1967 , that (I) (we) last saw the deceased alive on Mar 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Willard Applefeld		23B. DATE SIGNED 3/14/67	
23C. PHYSICIAN'S NAME (Type) DR. WILLIARD APPLEFELD		23D. ADDRESS PARK HEIGHTS & GLEN AVENUES	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3/14/67	24C. NAME of CEMETERY or CREMATORY SHAAREI TFILOH	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967	25B. NAME OF REGISTRAR R. E. TAYLOR	25C. FUNERAL DIRECTOR ADDRESS SOI LEVINSON & BROS. INC., 6010 REIST., RD.	

Handwritten text, possibly a signature or name, written in a cursive script. The text is oriented vertically and appears to be a name or title.

Handwritten text, possibly a signature or name, written in a cursive script. The text is oriented horizontally and appears to be a name or title.

Handwritten text, possibly a signature or name, written in a cursive script. The text is oriented horizontally and appears to be a name or title.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2619		CERTIFICATE OF DEATH		67 2619	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Lillian TANNENBAUM			3/13/67 11:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI Hospital of Baltimore, INC.			A. STATE MARYLAND B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			D. STREET ADDRESS (If rural, give location) 3005 NORTHERN PIKE		
5. SEX F	6. RACE CAU.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/25/96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harry Schuman			14. MOTHER'S MAIDEN NAME Ida ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Hospital Clerk		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4331/41260X			CAUSE OF DEATH (A) CARDIAC ARRHYTHMIA DUE TO (B) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH TERMINAL YEARS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS			YEARS		
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/8 19 67 to 3/13 19 67 , that (1) (we) last saw the deceased alive on 3/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. Brett Lazar				23B. DATE SIGNED 3/13/67	
23C. PHYSICIAN'S NAME (Type) J. Brett Lazar				23D. ADDRESS Sinai Hosp. of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/67		24C. NAME OF CEMETERY or CREMATORY Workmen Circle	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967			
25B. NAME OF REGISTRAR Robert E. Sabin		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reist., Rd.			

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10/22/2011

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

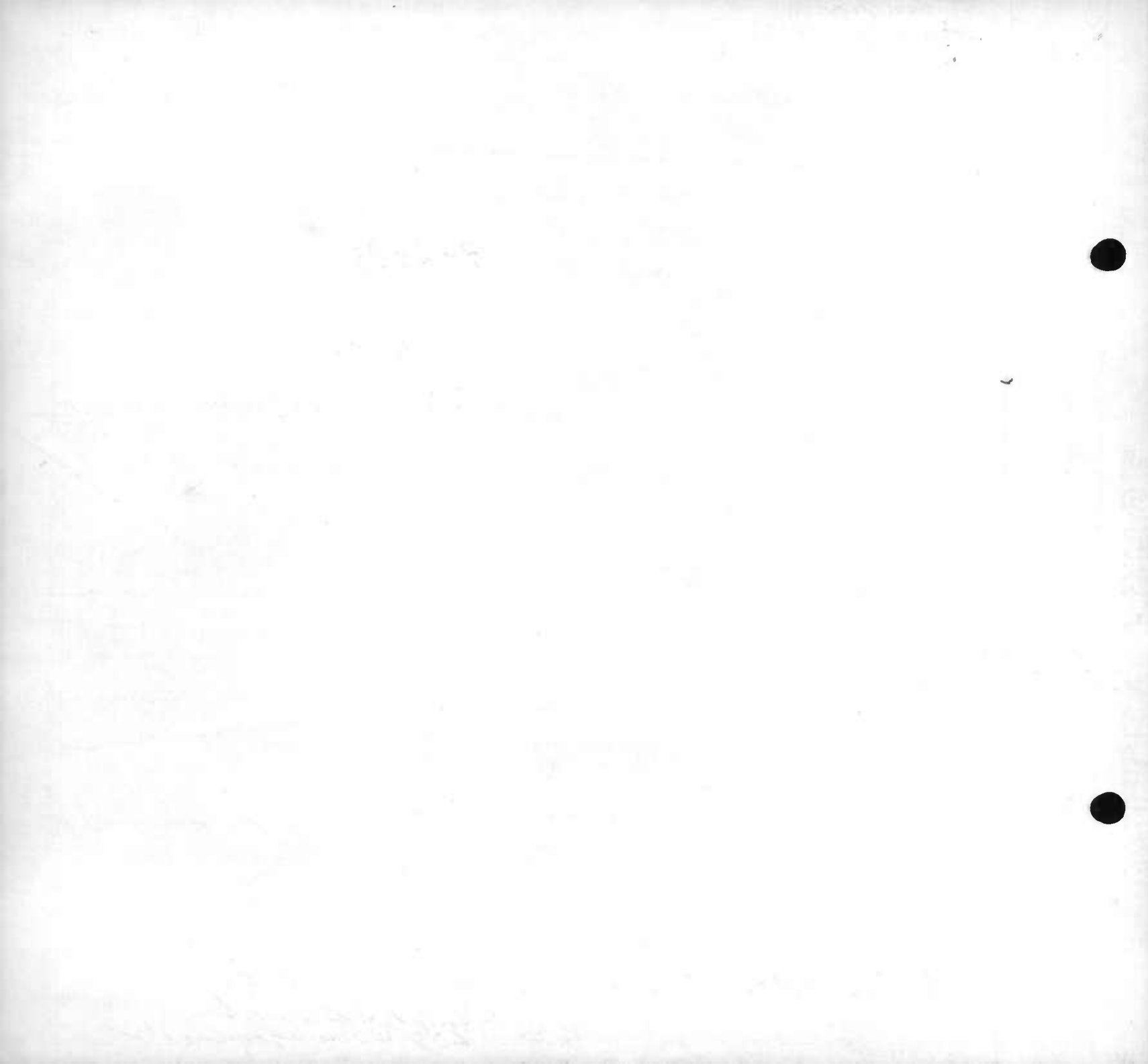
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 455 67 2620		CERTIFICATE OF DEATH		67 2620	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Louis Solomon		2. DATE AND HOUR OF DEATH March 11, 1967 8 ¹⁰ PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale, Hebrew Home and Infirmary -		A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. Co.	
		D. STREET ADDRESS (If rural, give location) 8122 SCOTTS LEVEL ROAD #8		53-00	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 76	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-2038		17. INFORMANT MR. ALLEN G. SOLOMON, 8122 SCOTTS LEVEL ROAD #8	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO myocardial infarction		4 weeks -	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO ASCVD			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb - 1967 to March 11 19 67, that (I) (we) last saw the deceased alive on March 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruth Willner		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 11, 1967	
23C. PHYSICIAN'S NAME (Type) Ruth Willner		23D. ADDRESS Levindale, Hebrew Home and Infirmary			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/13/67		24C. NAME of CEMETERY or CREMATORY SHADDEY TFILOH	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. MAR 17 1967		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. DATE	
SQL LEVINSON & BROS. INC., 6010 REIST., RD.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 2621	
BIRTH NO. 67 2621						CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Ella Mae Johnson</u>				2. DATE AND HOUR OF DEATH <u>14 March 1967</u> <u>12 30</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University of Maryland Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURA and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>732 S. Charles</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Sep</u>		8. DATE OF BIRTH <u>9-29-33</u>	9. AGE (In years last birthday) <u>33</u>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Ella Baker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sula Johnson</u>		ADDRESS <u>1530 Hamburg St</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>237X-1002.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Left cerebral tumor</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Possible Tuberculosis (not proven)</u>				CAUSE OF DEATH (A) <u>Left cerebral tumor</u> DUE TO (B) <u>-</u> DUE TO (C) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>> 1 wk</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>N/A</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>		22. I certify that (H) (this hospital) attended the deceased from <u>11 Mar</u> 19 <u>67</u> to <u>14 Mar</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 Mar</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Robert S. Holt</u>	
23B. DATE SIGNED <u>14 Mar 67</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert S. Holt</u>		23D. ADDRESS <u>University Hospital</u>		23E. FUNERAL DIRECTOR <u>Joseph Brown</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/18/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Ct</u>		24D. LOCATION (City, town, or county) (State) <u>Balt City</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1967</u>		25B. NAME OF REGISTRAR <u>Robert S. Holt</u>		25C. ADDRESS <u>208 N. Montgomery St</u>		25D. ADDRESS <u>208 N. Montgomery St</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

67 2622

Registered No.

67 2622

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THEODORE

COLE

2. DATE AND HOUR PRONOUNCED DEAD

March 14, 1967

12:30 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

521 Sharp Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

3-27-1911

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

L

10B. KIND OF BUSINESS OR INDUSTRY

Day Worker

11. BIRTHPLACE (State or foreign country)

Baltimore-Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

David Robinson

14. MOTHER'S MAIDEN NAME

Annie Cole

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lena Lewis- 903 Hardin Ct

18. E 983 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) 2nd Degree Burns of Trunk and Arms.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

521 Sharp Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 12 '67 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Burned in fire set by arsonist.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

3/14/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-18-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore-City

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1967

24B. NAME OF REGISTRAR

R. E. Farley, M.D.

24C. FUNERAL DIRECTOR

Isaiah L. Brown and Spn
108 W. Montgomery Street

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2623		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2623	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type and print) <i>Hawkins, Charles</i>		2. DATE AND HOUR OF DEATH <i>MARCH 15, 1967 9:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTO. MD.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns. Hopkins Hosp</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO. MD.</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1714 M. CALHOUN ST</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>5/9/84</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>CHARLES HAWKINS</i>			
14. MOTHER'S MAIDEN NAME <i>BETTY SHORT</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>219 18 6415</i>		17. INFORMANT ADDRESS <i>DOROTHY WILKENS 1714 CALHOUN ST.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic CVD</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Brain Syndrome</i>				<i>~ 5 years</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>3/19</i> 19 <i>67</i> to <i>3/15</i> 19 <i>67</i> , that (we) last saw the deceased alive on <i>3/15</i> 19 <i>67</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) not view the body after death.					
23A. SIGNATURE <i>Stephen W. Spaulding</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/15/1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>Stephen W. Spaulding</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3-20-67</i>		24C. NAME of CEMETERY or CREMATORY <i>NEW CATHARAL Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO., MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 17 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>NELSON FUNERAL HOME 1348 CALHOUN ST.</i>			

Handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and includes names and dates, such as "Hobbs", "1/10", "1/11", "1/12", "1/13", "1/14", "1/15", "1/16", "1/17", "1/18", "1/19", "1/20", "1/21", "1/22", "1/23", "1/24", "1/25", "1/26", "1/27", "1/28", "1/29", "1/30", "1/31", "2/1", "2/2", "2/3", "2/4", "2/5", "2/6", "2/7", "2/8", "2/9", "2/10", "2/11", "2/12", "2/13", "2/14", "2/15", "2/16", "2/17", "2/18", "2/19", "2/20", "2/21", "2/22", "2/23", "2/24", "2/25", "2/26", "2/27", "2/28", "2/29", "2/30", "3/1", "3/2", "3/3", "3/4", "3/5", "3/6", "3/7", "3/8", "3/9", "3/10", "3/11", "3/12", "3/13", "3/14", "3/15", "3/16", "3/17", "3/18", "3/19", "3/20", "3/21", "3/22", "3/23", "3/24", "3/25", "3/26", "3/27", "3/28", "3/29", "3/30", "3/31", "4/1", "4/2", "4/3", "4/4", "4/5", "4/6", "4/7", "4/8", "4/9", "4/10", "4/11", "4/12", "4/13", "4/14", "4/15", "4/16", "4/17", "4/18", "4/19", "4/20", "4/21", "4/22", "4/23", "4/24", "4/25", "4/26", "4/27", "4/28", "4/29", "4/30", "5/1", "5/2", "5/3", "5/4", "5/5", "5/6", "5/7", "5/8", "5/9", "5/10", "5/11", "5/12", "5/13", "5/14", "5/15", "5/16", "5/17", "5/18", "5/19", "5/20", "5/21", "5/22", "5/23", "5/24", "5/25", "5/26", "5/27", "5/28", "5/29", "5/30", "5/31", "6/1", "6/2", "6/3", "6/4", "6/5", "6/6", "6/7", "6/8", "6/9", "6/10", "6/11", "6/12", "6/13", "6/14", "6/15", "6/16", "6/17", "6/18", "6/19", "6/20", "6/21", "6/22", "6/23", "6/24", "6/25", "6/26", "6/27", "6/28", "6/29", "6/30", "7/1", "7/2", "7/3", "7/4", "7/5", "7/6", "7/7", "7/8", "7/9", "7/10", "7/11", "7/12", "7/13", "7/14", "7/15", "7/16", "7/17", "7/18", "7/19", "7/20", "7/21", "7/22", "7/23", "7/24", "7/25", "7/26", "7/27", "7/28", "7/29", "7/30", "7/31", "8/1", "8/2", "8/3", "8/4", "8/5", "8/6", "8/7", "8/8", "8/9", "8/10", "8/11", "8/12", "8/13", "8/14", "8/15", "8/16", "8/17", "8/18", "8/19", "8/20", "8/21", "8/22", "8/23", "8/24", "8/25", "8/26", "8/27", "8/28", "8/29", "8/30", "8/31", "9/1", "9/2", "9/3", "9/4", "9/5", "9/6", "9/7", "9/8", "9/9", "9/10", "9/11", "9/12", "9/13", "9/14", "9/15", "9/16", "9/17", "9/18", "9/19", "9/20", "9/21", "9/22", "9/23", "9/24", "9/25", "9/26", "9/27", "9/28", "9/29", "9/30", "10/1", "10/2", "10/3", "10/4", "10/5", "10/6", "10/7", "10/8", "10/9", "10/10", "10/11", "10/12", "10/13", "10/14", "10/15", "10/16", "10/17", "10/18", "10/19", "10/20", "10/21", "10/22", "10/23", "10/24", "10/25", "10/26", "10/27", "10/28", "10/29", "10/30", "10/31", "11/1", "11/2", "11/3", "11/4", "11/5", "11/6", "11/7", "11/8", "11/9", "11/10", "11/11", "11/12", "11/13", "11/14", "11/15", "11/16", "11/17", "11/18", "11/19", "11/20", "11/21", "11/22", "11/23", "11/24", "11/25", "11/26", "11/27", "11/28", "11/29", "11/30", "12/1", "12/2", "12/3", "12/4", "12/5", "12/6", "12/7", "12/8", "12/9", "12/10", "12/11", "12/12", "12/13", "12/14", "12/15", "12/16", "12/17", "12/18", "12/19", "12/20", "12/21", "12/22", "12/23", "12/24", "12/25", "12/26", "12/27", "12/28", "12/29", "12/30", "12/31".

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2624**

BIRTH NO. **67 2624**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
TURNER DYSON		3-14-67 3:10 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1003 Vine Street - Amb. Crew #4		A. STATE Maryland	
		B. COUNTY Baltimore	
5. SEX Male		6. RACE Colored	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH 1-17-1887	
9. AGE (in years last birthday) 80		10. IF Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ST. MARY'S CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN R.W. DYSON		14. MOTHER'S MAIDEN NAME MARY L. WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 220-09-3254	
17. INFORMANT Mrs. Agnes Finch		ADDRESS 4 N. Spring Street	
18. 722.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO (A) _____ (B) _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-15-67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-20-67	
23C. NAME of CEMETERY or CREMATORY Balto. Nat'l Cem.		23D. LOCATION (City, town, or county) (State) Balto., Maryland	
24A. DATE REC'D BY HEALTH DEPT. MAR 17 1967		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	

WALTER PATER

THE LIFE OF

WALTER PATER

BY

ALAN

WATSON

AND

JOHN

WATSON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2625BIRTH NO. 67 2625

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

WASHINGTON

2. DATE AND HOUR PRONOUNCED DEAD

March 15, 1967

4:35 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)42 Sinai Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2214 Whittier Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

5-1-1901

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

GENERAL SERVICE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

BESSIE WASHINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Bertha Washington 2214 Whittier

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-20-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Morton & Dyett F.H. 1701 Laurens St.

ADDRESS

ALLEN PAPERS

144 FOLIO

THE CHURCH

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2626			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Thomas L. Howell</u>				2. DATE AND HOUR OF DEATH <u>3-15-67</u> <u>3:45A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>1801</u> <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u>				D. STREET ADDRESS (If rural, give location) <u>18 N. Poppleton Street</u>				E. DATE OF BIRTH <u>12-4-11</u>			
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>12-4-11</u>		9. AGE (In years last birthday) <u>55</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			
13. FATHER'S NAME <u>Groves Howell</u>				14. MOTHER'S MAIDEN NAME <u>Helen Howell</u>				12. CITIZEN OF WHAT COUNTRY?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-10-8824</u>				17. INFORMANT <u>Idea Mae Howell 18 N. Poppleton St.</u>			
18. <u>422.1-260X</u>				CAUSE OF DEATH				ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <u>ACUTE MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO							
ANTECEDENT CAUSES				(B) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>				SEVERAL YEARS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO							
(C) <u>DIABETES MELLITUS, ACIDOSIS</u>								2 DAYS			
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (this hospital) attended the deceased from <u>2-13</u> 19 <u>67</u> to <u>3-15</u> 19 <u>67</u> , that (we) lost saw the deceased alive on <u>3-15</u> 19 <u>67</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Harold A. Burnham</u> M.D.				23B. DATE SIGNED <u>3-15-67</u>							
23C. PHYSICIAN'S NAME (Type) <u>Harold A. Burnham</u> M.D.				23D. ADDRESS <u>1213 Light Street</u>							
24A. BURIAL CREMATION, REMOVAL (specify) <u>Burial</u>		24B. DATE <u>3/18/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Cedar Hill Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>W. J. F. Jones</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		ADDRESS <u>317 N. Schroeder St.</u>					

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1
S-120

67 2627

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 2627

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **FRANCES SOBUS** 2. DATE AND HOUR PRONOUNCED DEAD **March 15, 1967 6:45 P M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **00 410 S. Bethel Street** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **00 410 S. Bethel Street** 5. SEX **Female** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Single** 8. DATE OF BIRTH **1/8/1889** 9. AGE (In years last birthday) **78** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Dressmaker** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Francis Sobus** 14. MOTHER'S MAIDEN NAME **Marcella Poremski**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **-** 16. SOCIAL SECURITY NO. **217-03-8770** 17. INFORMANT **Mr. Charles Sobus, 803 N. Patterson Pk. Ave**

18. **42001** CAUSE OF DEATH **Arteriosclerotic Heart Disease.** INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Arteriosclerotic Heart Disease.**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. **(A) Arteriosclerotic Heart Disease.**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **(B) DUE TO**

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **No** 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)** **21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Petty** CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **3/16/67**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **3/17/67** 23C. NAME OF CEMETERY or CREMATORY **Sacred Heart of Mary** 23D. LOCATION **Baltimore, Maryland**

24A. DATE REC'D BY HEALTH DEPT. **24B. NAME OF REGISTRAR** **24C. FUNERAL DIRECTOR** **M.F. SADOWSKI & SONS, 1808 EASTERN AVE**

VS 151-REV. 1/67 **MAR 17 1967** **2635**

VALLEY VIEW
WASHILLBY FORD

FOR THE COMMISSION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

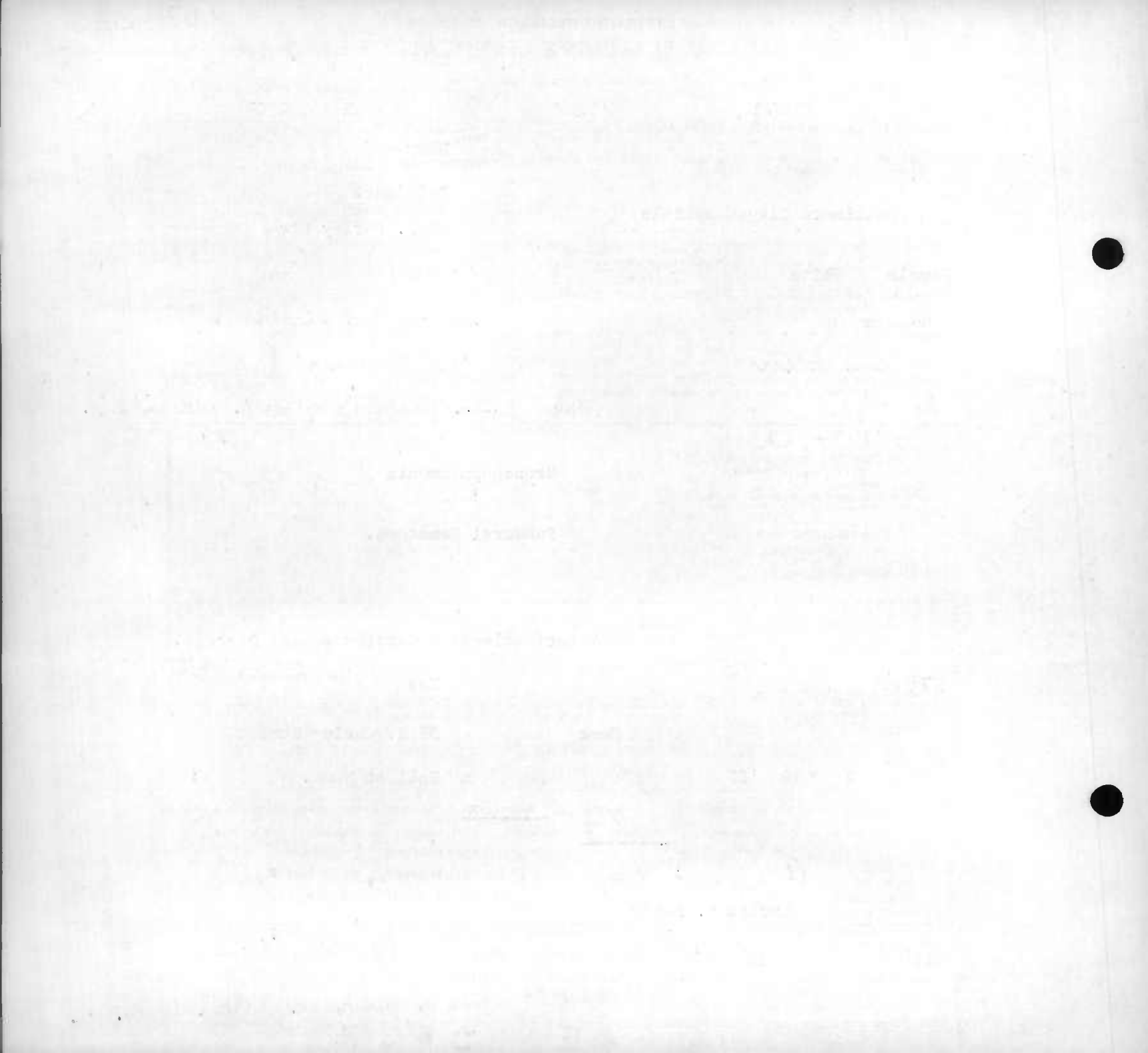
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. X 67 2628						
BIRTH NO. 67 2628					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) ANITA A. BLACKSTONE					2. DATE AND HOUR OF DEATH 16 MARCH 1967 7 ³⁵ A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL					A. STATE MD B. COUNTY BALTO A.A.C.						
5. SEX F					6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH 4/26/1894		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) 72		11. BIRTHPLACE (State or foreign country) MD.		
13. FATHER'S NAME John JACKSON (dec)					14. MOTHER'S MAIDEN NAME Katie Jackson		12. CITIZEN OF WHAT COUNTRY? USA		17. INFORMANT Helen Eldridge - Hanover Md.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		18. CAUSE OF DEATH		ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 054X I					(A) DUE TO Septic shock					INTERVAL BETWEEN ONSET AND DEATH 7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO						
(C) DUE TO											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 12 Mar 67					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Resp Insuff		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 8 MAR 19 67 to 16 MAR 19 67, that (I) (we) lost saw the deceased alive on 16 MAR 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Stanley Music					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 16 MAR 67				
23C. PHYSICIAN'S NAME (Type) STANLEY MUSIC					23D. ADDRESS % UNIVERSITY HOSPITAL						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-19-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park			24D. LOCATION (City, town, or county) (State) Arbutus Md			
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967			25B. NAME OF REGISTRAR R. E. F. F.			25C. FUNERAL DIRECTOR Lynell B. Eden - Balto. Md.			ADDRESS		



A 600

67 2629		BALTIMORE CITY HEALTH DEPARTMENT		67 2629	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
BEULAH AIREY		March 14, 1967		2:10 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
31 Baltimore City Hospitals		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 37 S. Curley Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Widowed	4/14/1889	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Princess Ann, Virginia	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?			
James Walters		USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Mrs. Joseph Quade 23 N. Linwood Ave.	
18. <u>E 904.0</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Bronchopneumonia			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO Subdural Hematoma.			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic Cardiovascular Disease.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		37 S. Curley Street 1-02	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Fall at home.	
2		14 '67			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		3/16/67		Willow Wood Cemetery	
				23D. LOCATION (City, town, or county) (State)	
				Norfolk, Virginia	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAR 17 1967		Robert E. Fairbank		John A. Moran, Inc. 3000 E. Balto. St.	

N 854-967000 2637



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2630		Registered No. 67 2630	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>Ernest H. Keckler</i>				2. DATE AND HOUR OF DEATH <i>March 15, 1967</i> <i>8:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 3609 Old York Road</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-03</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3609 Old York Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>1/22/1893</i>	9. AGE (In years lost birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Special Police Guard Hecht Co.</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Waynesboro, Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Keckler</i>			14. MOTHER'S MAIDEN NAME <i>Melinda Jane Poffenberger</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>579-16-6921</i>		17. INFORMANT <i>Donald R. Keckler 4010 Rockville, Md. Elizabeth St.</i>		
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Arteriosclerotic Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>1965</i> 19 to <i>March 15</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 14</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Loy M. Zimmerman</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <i>3/15/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman</i>						23D. ADDRESS <i>3202 Harford Rd, Baltimore, Md</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/18/1967</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 17 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Baltimore St.</i>			

After school study

March 24, 1907

To Mr. [unclear]
[unclear]

100 [unclear]

1
K-530

67 2631

BALTIMORE CITY HEALTH DEPARTMENT

67 2631

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		JAMES C. KENT		2. DATE AND HOUR PRONOUNCED DEAD March 14, 1967 12:25 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2770 Kinsey Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2770 Kinsey Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/15/02	9. AGE (In years last birthday) 64	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Kent		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Laura Kent 2770 Kinsey Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Artery Embolism DUE TO Thrombophlebitis, Left Popliteal Venous System. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Petty</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/14/67					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/19/67	23C. NAME of CEMETERY or CREMATORY Arbutus Memorial Pk.		23D. LOCATION (City, town, or county) (State) Laurel, Maryland
24A. DATE REC'D BY HEALTH DEPT. MAR 17 1967		24B. NAME OF REGISTRAR Robert E. Farley		24C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.	

19670002639

42

WALLLEY
POLICE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2632	
BIRTH NO. 67 2632		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HENSON, BESSIE		2. DATE AND HOUR OF DEATH 14. 3. 67 3:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2010. N. Bentalan St.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) widowed	8. DATE OF BIRTH 1-10-88	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H/W		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign Country) WASHINGTON D.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benjamin Gross		14. MOTHER'S MAIDEN NAME GROSS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS FLORENCE HARDMAN, 2010. N. Bentalan St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Diab DIABETIC KETO ACIDOSIS AND UREMIA (B) SEVERE PYELOCYSTITIS (C) R.L. PNEUMONIA. ACUTE ANT. LATERAL WALL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-13-67 1967 to 3-14 1967, that (I) (we) last saw the deceased alive on 3-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Biswanath Pillai				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) V. BISWANATH PILLAI				23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/67		24C. NAME of CEMETERY or CREMATORY Carrow Men Park Laurel Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967			
25B. NAME OF REGISTRAR Robert E. Talbott		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barrett			

Memorandum

14-12-67

MEMORANDUM

LUTHERAN HOSPITAL OF MARYLAND BALTIMORE

BUILDING 3

14-12-67

ROUTED

F C

14-12-67

WASHINGTON D.C.

14-12-67

6000

FLORANCE HARRISON

SEVERE PNEUMONIA

ALL CRIMINAL

SEVERE PNEUMONIA

SEVERE PNEUMONIA

SEVERE PNEUMONIA

14-12-67

14-12-67

14-12-67

14-12-67

14-12-67

FLORANCE HARRISON

LUTHERAN HOSPITAL OF MARYLAND

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDITH BROWN

2. DATE AND HOUR PRONOUNCED DEAD

3-14-67 6:15 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

521 S. Sharp Street 21201

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/24/21

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Humphrey Mills

14. MOTHER'S MAIDEN NAME

Armed Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James Brown 137 W. Hill St.

18. E983X1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH(A) Edema of larynx and lungs, and acute
Pancreatitis complicating inhalation of smoke

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

521 S. Sharp Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 12 '67 PM 7:38

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Burned in fire (Arson)

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-15-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/20/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

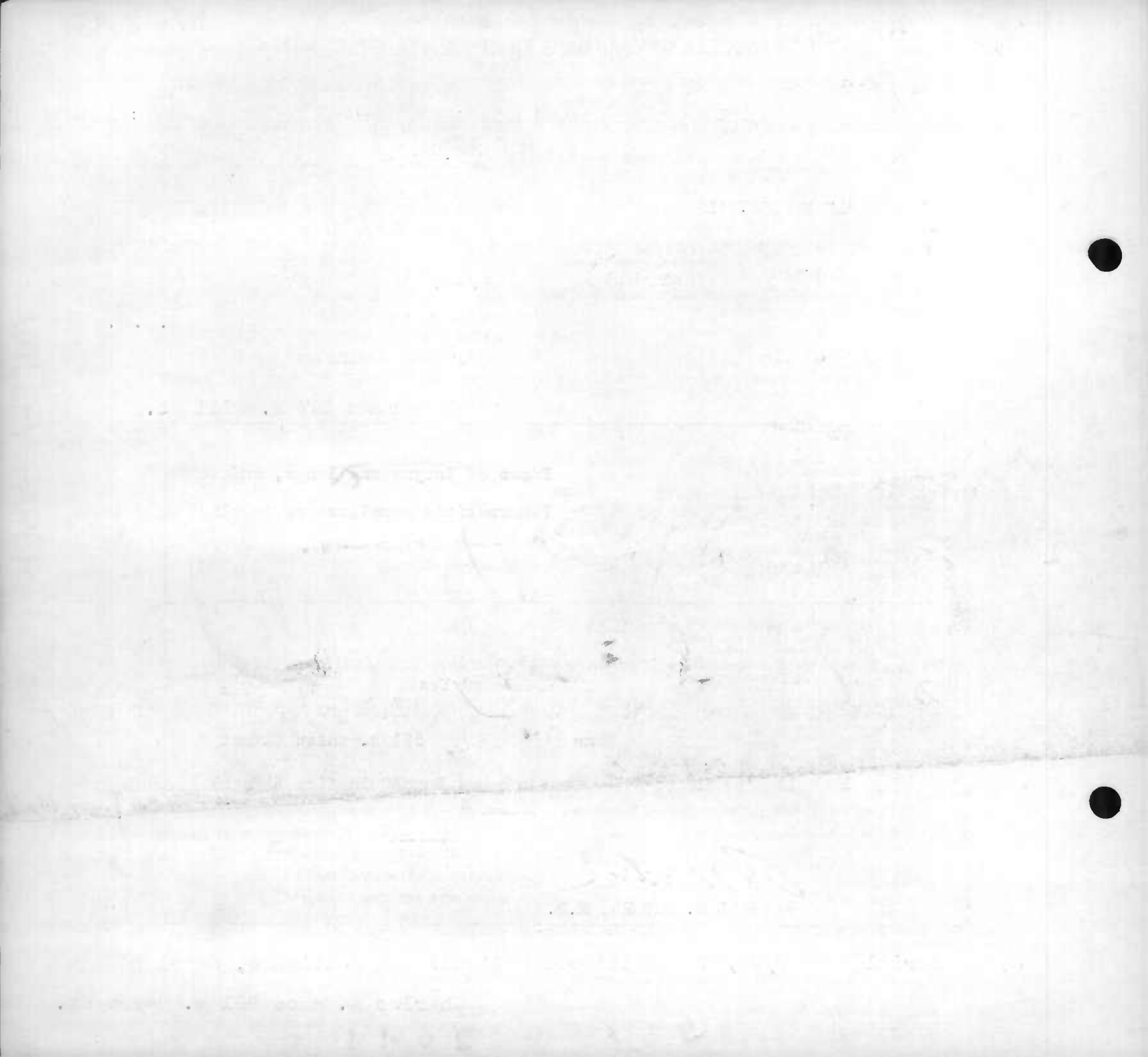
24C. FUNERAL DIRECTOR

ADDRESS

MAR 17 1967

Robert E. Fairbank

Charles A. Rice 661 W. Barre St.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2634BIRTH NO. 67 2634

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERNARD Thomas DOUGHERTY

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1967 5:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 5208 Greenwich Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5208 Greenwich Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 9, 1902

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Andrew I. Dougherty

14. MOTHER'S MAIDEN NAME

Margaret Cluney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

223-07-9602

17. INFORMANT

Mrs. B. Thomas Dougherty ADDRESS
5208 Greenwich Ave. - 21229

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-18-67

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Witzke F. D. - 4101 Edmondson Ave.

AVAILABLE FOR RENT

2127 1st St. N. S.W.

PHENIX

5-567 2635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2635

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Smith, Dorothy</i>		2. DATE AND HOUR OF DEATH <i>3/14/67</i> <i>9:45</i> a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i>		(If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Avenue</i> <i>Baltimore 21224, Maryland</i>		A. STATE <i>Maryland</i>		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		<i>Baltimore</i>		<i>12-04</i> <i>403 21 1/2 Street</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>3-15-17</i>	9. AGE (In years lost birthday) <i>50</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John</i>				14. MOTHER'S MAIDEN NAME <i>Fannie</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 Eastern Ave. #21224</i>			
18. <i>00211</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary tuberculosis</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Peritonitis</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i> <i>1 wk</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/11/67</i> 19 <i>67</i> to <i>Mar 14</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>Mar 14</i> 19 <i>67</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(X)</i> (We) <i>(did)</i> (did not) view the body after death.							
23A. SIGNATURE <i>Mary Ann Sullivan</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Mary Ann Sullivan</i>				23D. ADDRESS <i>Baltimore City Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3/18/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Adolphus Halstead</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>		ADDRESS <i>1206 W North Ave</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

with the staff

3/11/61

Reference to
Perkins

3/11/61

Walter Sullivan

1000 Ave. 21st St.

Baltimore, Md.

BIRTH NO. 67 2636

67 2636

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SILAS

DEES

2. DATE AND HOUR PRONOUNCED DEAD

3-14-67

5:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

615 W. FRANKLIN STREET - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

615 W. Franklin Street

21201

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

12/9/22

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wilmington N Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Silas

14. MOTHER'S MAIDEN NAME

Rosie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
246-07-0343

17. INFORMANT

ADDRESS

Mrs Sarah Dees 1804 Eutaw Place

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Intracerebral hemorrhage - (pons)

DUE TO

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-15-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/21/67

23C. NAME of CEMETERY or CREMATORY

National Cemetry

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 17 1967

R. E. Fisher, M.D.

Adolphus Halstead 1206 W North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2632</u>	
BIRTH NO. <u>67 2632</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BERTHA FINNEY</u>		2. DATE AND HOUR OF DEATH <u>March 14-1967</u> <u>10⁴⁵ A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2830 W Lanvale St</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-23-01</u>	9. AGE (In years lost birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
13. FATHER'S NAME <u>—</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>—</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Severe dehydration + electrolyte imbalance</u> <u>Aspiration pneumonia</u> <u>Intestinal obstruction</u> <u>previous pelvic surgery</u>			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>Arteriosclerotic heart disease</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>3-14</u> 19 <u>67</u> to <u>3-14</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-14</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. Mamaril, Jr.</u> M.D.				23B. DATE SIGNED <u>3-14-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Anselmo MAMARIL, JR.</u>		23D. ADDRESS <u>—</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/18/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetr</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1967</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North Ave</u>	

Butcher Hospital

F N W-land

A. Macnamara, Jr.
Anselmo Macnamara, Jr.

Notar Public for the State of
New York
James J. Macnamara
Notary Public for the State of
New York

1-23-01 to
Butcher

22 30 in 10000 24
Butcher
1-23-01 to

3-14-02
X
3-14-02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2638	
BIRTH NO. 67 2638		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN PITTS		2. DATE AND HOUR OF DEATH 3/16/67 4:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTIMORE		A. STATE MARYLAND, BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-15			
		D. STREET ADDRESS (If rural, give location) BAR WIL BA Nursing home			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID.	8. DATE OF BIRTH 6/10/83	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Bilateral Bronchopneumonia DUE TO (B) Cerebral Thrombosis DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH 7 days 14 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 3 19 67 to March 16 19 67 , that (I) (we) last saw the deceased alive on March 16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE A. Levy				23B. DATE SIGNED 3/16/67	
23C. PHYSICIAN'S NAME (Type) ABE LEVY		23D. ADDRESS M.D. SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar. 2/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial	
24D. LOCATION Baltimore		24E. NAME OF REGISTRAR Robert E. Fink		24F. FUNERAL DIRECTOR La. Brooks Ruggold	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 14637 Lee St	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

George F. Lee

2. DATE AND HOUR PRONOUNCED DEAD

16 March 1967 7:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2200 Wilkens Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2200 Wilkins Ave.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

March 11, 1900

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

City Gov't

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William C. Lee

14. MOTHER'S MAIDEN NAME

Cecelia Wolf

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

World War II

16. SOCIAL
SECURITY NO.

215-01-8868

17. INFORMANT

ADDRESS

Anna M. Lee 2200 Wilkins Ave.

18. CAUSE OF DEATH

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

I. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/16/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-20-67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION (City, town, or county)

Baltimore, Md

24A. DATE RECEIVED BY HEALTH DEPT.

MAR 17 1967

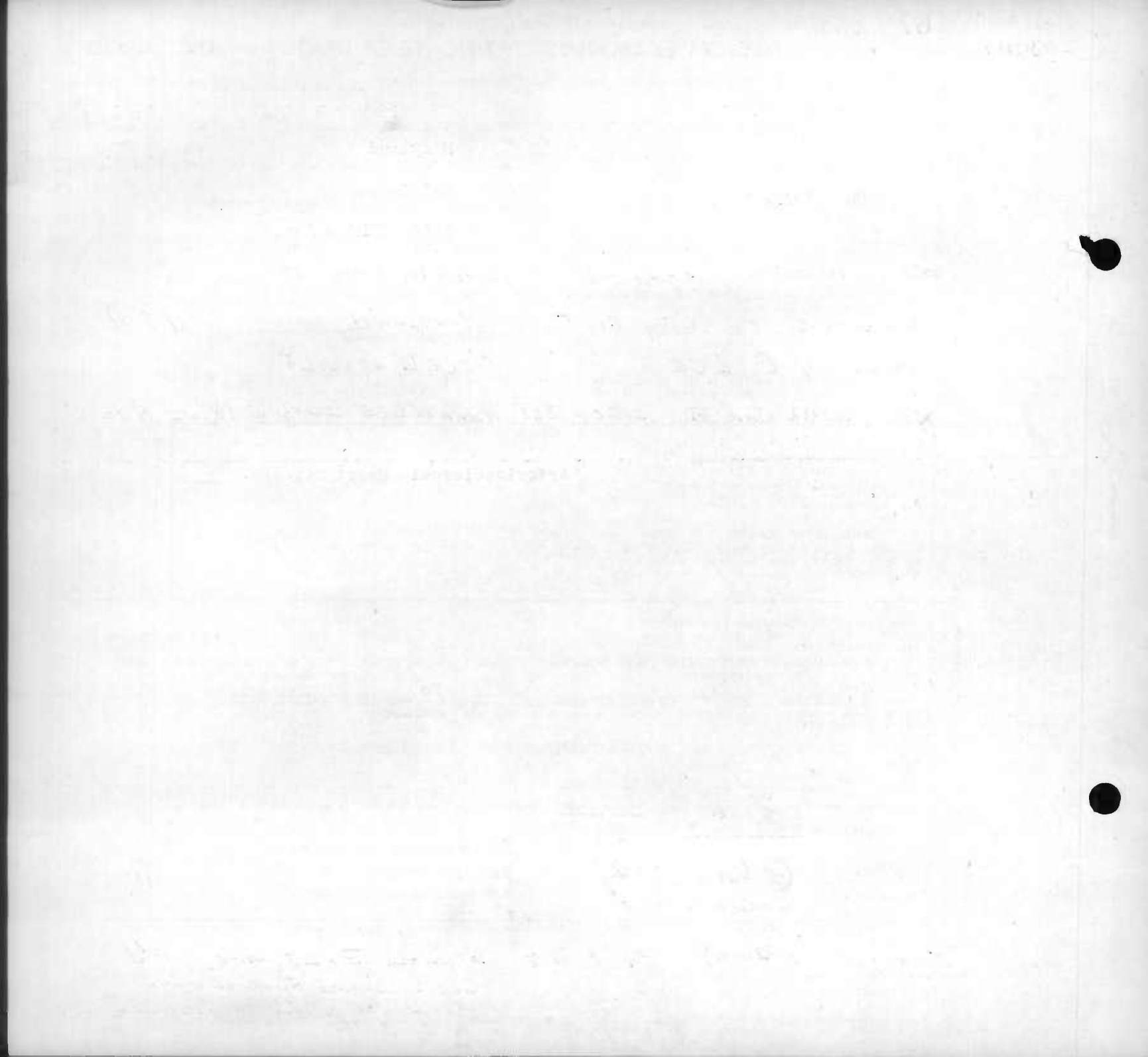
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home
Francis H. Miller 2101 Frederick Ave.

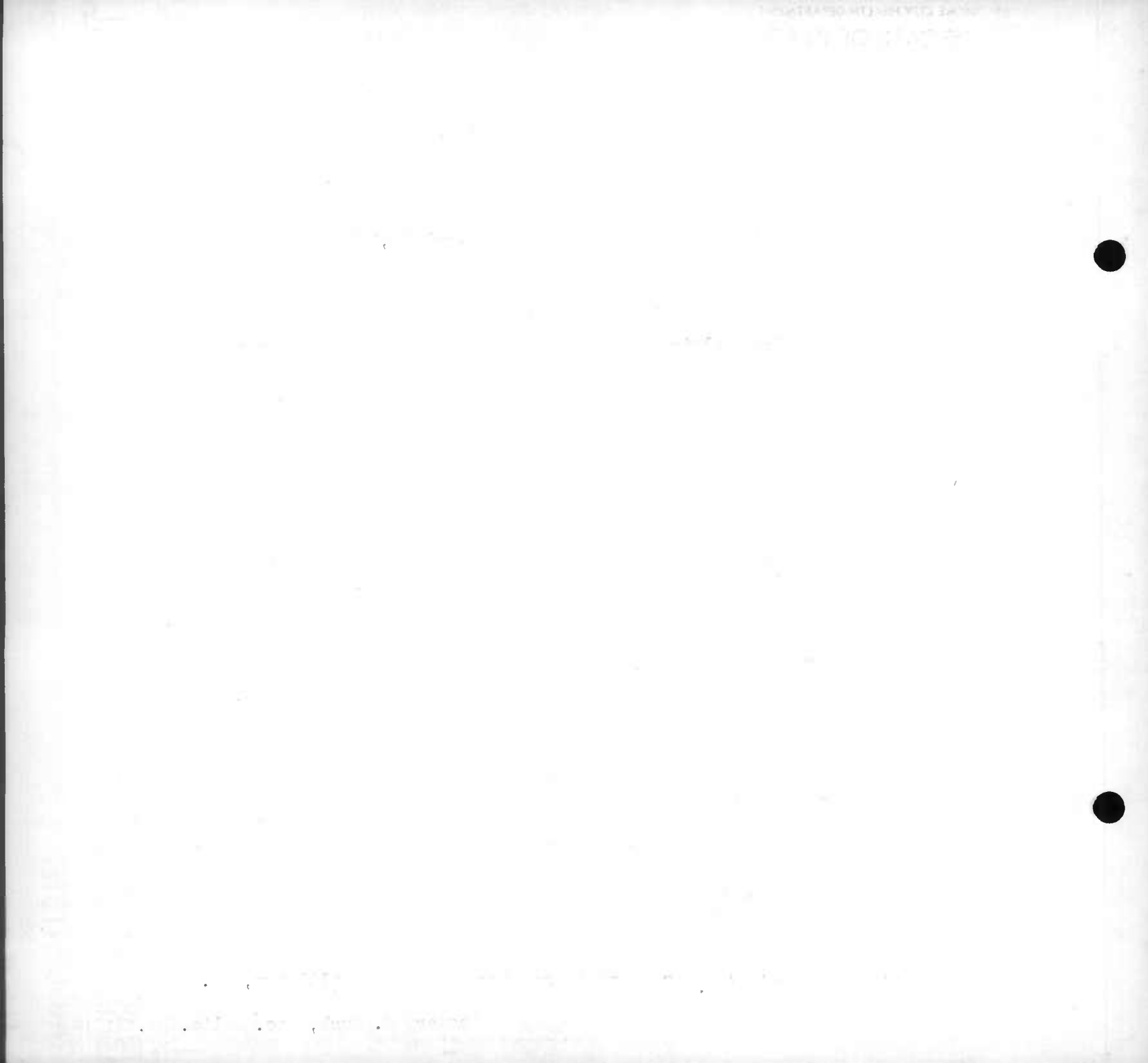
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2640		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2640	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>John Balsis</i>			2. DATE AND HOUR OF DEATH <i>3-16-67 5:15A. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>North Charles General Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21214</i> D. STREET ADDRESS (If rural, give location) <i>5320 Catapho Rd</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 22, 1898</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Medicist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>J. Sekine Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>	
13. FATHER'S NAME <i>Andrew Balsis</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-03-4783</i>		17. INFORMANT <i>Helen Balsis</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Massive pulmonary Emboli - recent</i> <i>Carcinoma, stomach</i> <i>met. to liver (worsen)</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>March 6</i> 19 <i>67</i> to <i>March 16</i> 19 <i>67</i> , that (I) <i>last</i> saw the deceased alive on <i>March 15</i> 19 <i>67</i> and that in (my) <i>apinian</i> death occurred on the date and hour and from the causes stated above. (I) <i>(did)</i> view the body after death.					
23A. SIGNATURE <i>Marion Friedmann</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>3-16-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARION FRIEDMANN</i>				23D. ADDRESS <i>5211 Harford Road Baltimore 4 MD.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>3/20/67.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Crematory</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 17 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

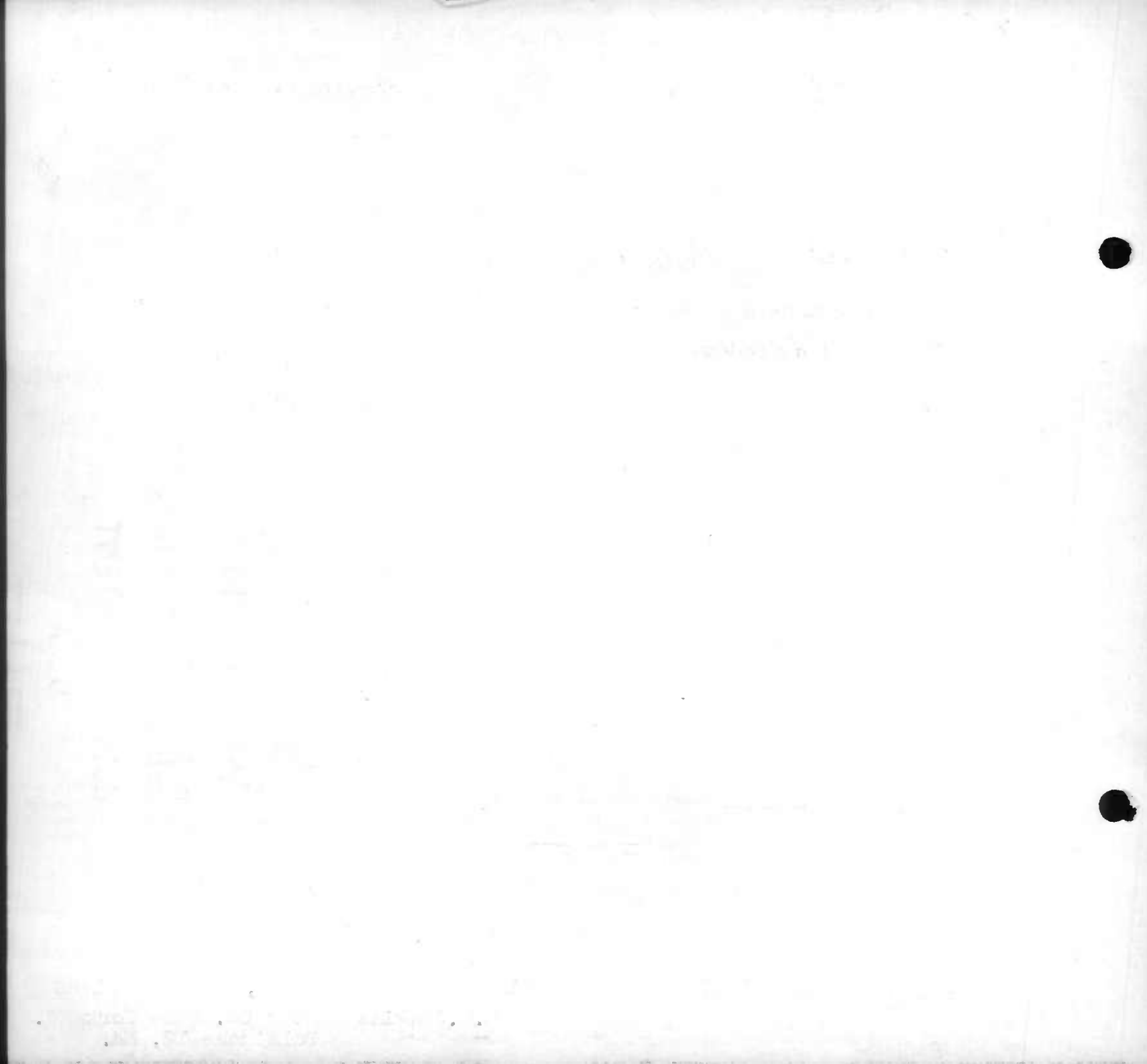
BIRTH NO. 67 2641		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2641	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) JAMES HOWARD VAN DANIKER			March 14, 1967 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP. D.O.A.			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 718 East 30th Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 6, 1905	9. AGE (in years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		10B. KIND OF BUSINESS OR INDUSTRY Cab. Co.	11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Van Daniker			14. MOTHER'S MAIDEN NAME Julia Etta Deckman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-0151		17. INFORMANT ADDRESS Raymond Van Daniker 718 E. 30 Th Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Aortic Stenosis (B) DUE TO (C) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 6 years 1 hour					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 5, 1950 to March 14th, 1967, that (I) (we) last saw the deceased alive on March 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Daniel Miller M.D.			23B. DATE SIGNED 3/15/67		
23C. PHYSICIAN'S NAME (Type) Daniel Miller			23D. ADDRESS M.D. 4321 Harford Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/67		24C. NAME OF CEMETERY or CREMATORY Baltimore Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Wm. Cook-Brooks Inc.		1217 St. Paul St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2642	
BIRTH NO. 67 2642				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ALICE MARY HEPBURN		2. DATE AND HOUR OF DEATH MARCH 16, 1967 8⁰⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 4 E. 32nd St.			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 10-14-91	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MICHAEL J. HEPBURN		14. MOTHER'S MAIDEN NAME ELIZABETH ROWLEY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. VIK.		17. INFORMANT SISTER - ELIZABETH HEPBURN		ADDRESS (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) 331X I		CAUSE OF DEATH (A) ARTERIOSCLEROSIS, GENERALIZED DUE TO (B) (R) Intracerebral Hemorrhage DUE TO (C) C Intraventricular Extension		INTERVAL BETWEEN ONSET AND DEATH 20 yrs. 4 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		N/A			
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A	
21D. TIME OF INJURY (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N/A		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from MARCH 16 5⁰⁰ 1967 to MARCH 16 8⁰⁰ 1967 , that (I) (we) last saw the deceased alive on MARCH 16 8⁰⁰ 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard S. Karpas M.D.				23B. DATE SIGNED Mar 16 '67	
23C. PHYSICIAN'S NAME (Type) BERNARD S. KARPAS Sr. M.D. M.D.		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/20/1967	24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967		25B. NAME OF REGISTRAR W. H. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

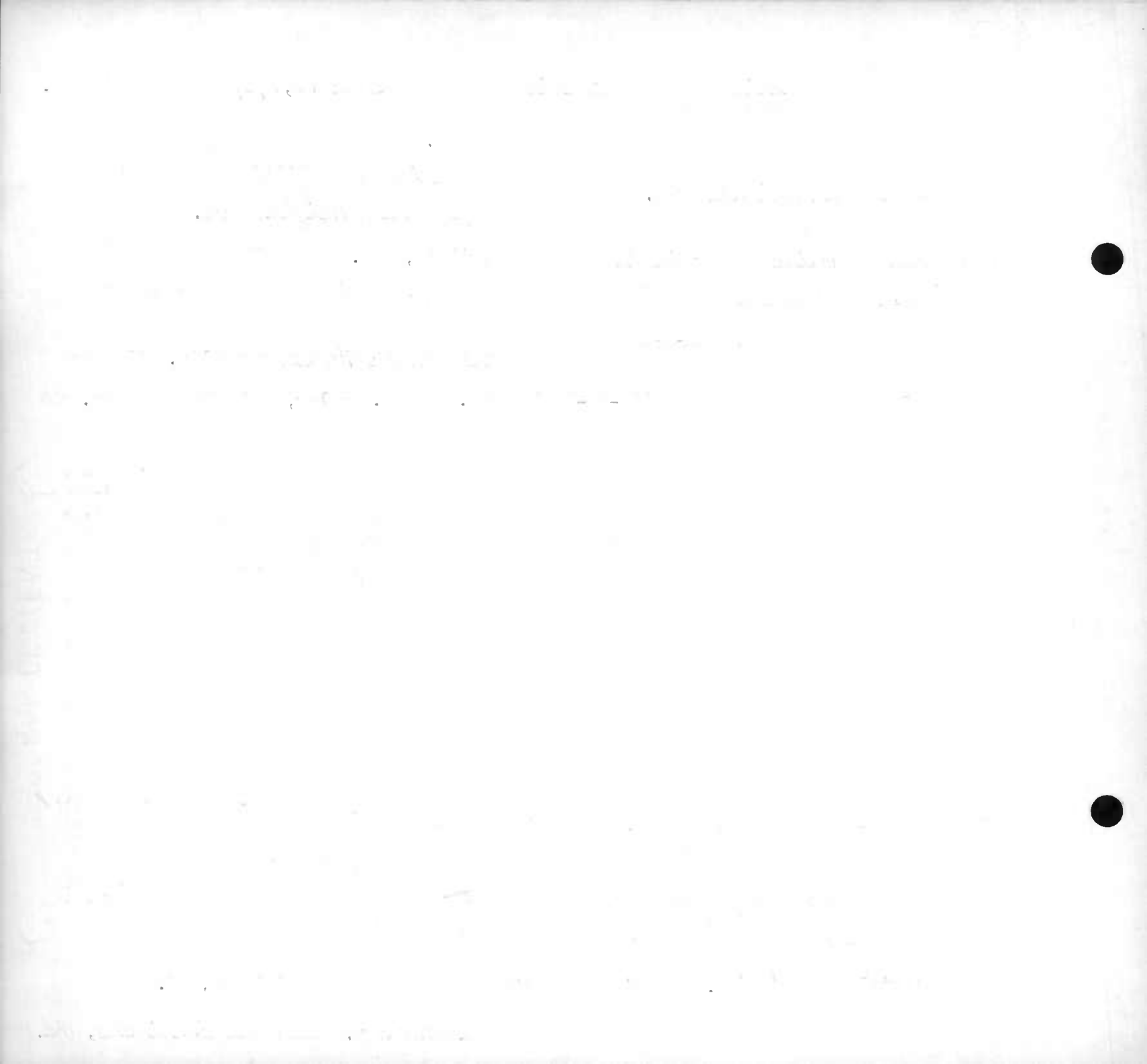
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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 2643	
BIRTH NO. 67 2643		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elizabeth Isaac		2. DATE AND HOUR OF DEATH March 16, 1967 11 40 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-12 D. STREET ADDRESS (If rural, give location) 301 Tunbridge Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 9-27-1896	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman		10B. KIND OF BUSINESS OR INDUSTRY Hecht Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank R. Isaac		14. MOTHER'S MAIDEN NAME Naamah Champayne		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-03-3555		17. INFORMANT Mrs. Naamah S. Browning			ADDRESS (Same)		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Malignant Brain Tumor ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				INTERVAL BETWEEN ONSET AND DEATH 8			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 3, 1967 to MARCH 16, 1967 , that (I) (we) last saw the deceased alive on MARCH 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sami Brahimi M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/16/67			
23C. PHYSICIAN'S NAME (Type) SAMI BRAHIMI		23D. ADDRESS Bon Secours Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/20/1967	24C. NAME of CEMETERY or CREMATORY Mt. Olivet		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

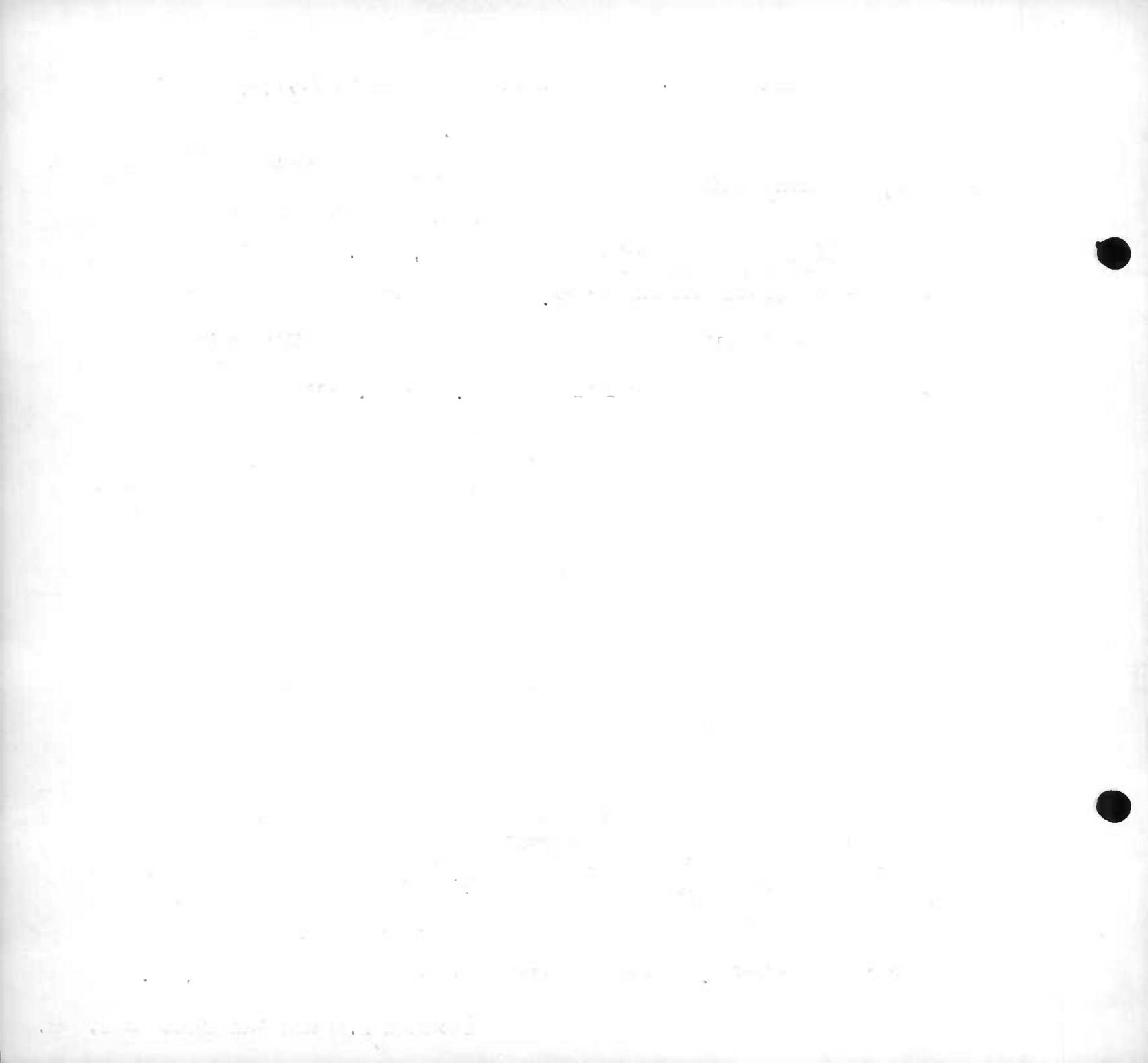
BALTIMORE CITY AND COUNTY				BIRTH NO. 67 2644		CERTIFICATE OF DEATH		Registered No. 67 2644	
1. NAME OF DECEASED (Type or Print) <i>Carrie Borleis</i>				2. DATE AND HOUR OF DEATH <i>March 16, 1967</i>				6 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4838 Park Heights Ave.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21215</i>		D. STREET ADDRESS (If rural, give location) <i>4838 Park Heights Ave.</i>	
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>single</i>	8. DATE OF BIRTH <i>April 10, 1887.</i>	9. AGE (in years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Seamstress</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Henry Borleis</i>				14. MOTHER'S MAIDEN NAME <i>Mrs. Mabel Taylor Mary Eliz. Hildeband</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>212-03-7431</i>		17. INFORMANT ADDRESS <i>Mrs. Rose M. Taylor, 2513 Hillcrest Ave. #34</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.0 Pulmonary embolism</i>				CAUSE OF DEATH (A) DUE TO <i>Pulmonary embolism</i> (B) DUE TO <i>Arteriosclerotic Heart Disease with episodes of sinus bradycardia</i> (C) <i>sinus bradycardia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3.16.67</i> <i>instantaneous</i> <i>1.1.64</i>	
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> 1964 to <i>March 16</i> 1967, that (I) was saw the deceased alive on <i>March 16</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Milton E. Lowman</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3.17.67</i>	
23C. PHYSICIAN'S NAME (Type) <i>MILTON E. LOWMAN</i>						23D. ADDRESS <i>4838 Park Heights Ave Balto 15 Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/20/67.</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 17 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. [unclear]</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2645		CERTIFICATE OF DEATH		67 2645	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Harry F. Hall		March 16, 1967 6 25 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
00 3119 Northway Drive				Md.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore 21234 27-05	
				D. STREET ADDRESS (If rural, give location)	
				3119 Northway Drive	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
male	white	Married	March 4, 1900.	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Chief Operator Standard Oil Co.			Maryland		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Hall			Lilly Lewis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-07-2340		Mrs. Sarah E. Hall (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Obstructive Emphysema 5 years	
ANTECEDENT CAUSES		(B) DUE TO		Chronic Bronchitis 10 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		Cor Pulmonale 2 years	
				Chronic progressive Emphysema 5 yrs.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1955 to March 16 1967, that (I) (we) last saw the deceased alive on March 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John H. Hirschfeld M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				3/16/1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN H. HIRSCHFELD M.D.		6919 Hanford Rd Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/20/67.		Gardens of Faith Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 17 1967		L. E. E. E. E. E.		Leonard J. Ruck Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 2646	
BIRTH NO. 67 2646		M.E. CASE NO. 67-03287								CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LORIZA FORERO						2. DATE AND HOUR OF DEATH 3-14-67 12.00 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7131 BEXHILL ROAD 21207					
5. SEX WHITE		6. RACE FEMALE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH 2-19-67		9. AGE (In years last birthday) --		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HUMBERTO FORERO						14. MOTHER'S MAIDEN NAME CECILIA PEREZ					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT 7131 Bexhill Road Balto. Md. Mr. Humberto Forero					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) Pneumonia DUE TO (B) Complications post-op for DUE TO (C) ligation of PDA				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 3/10/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Patent Ductus		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Not While At Work		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 3/10 1967 to 3/14 1967, that (2) we last saw the deceased alive on 3/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE R. L. Hurwitz M.D.						23B. DATE SIGNED 3/15/67			23C. PHYSICIAN'S NAME (Type) Richard L. Hurwitz M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial						24B. DATE 3/17/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore, Maryland 21213					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2647		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2647	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Chester J. Adams		
2. DATE AND HOUR OF DEATH 3/13/67 1:15 M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND Bolton Hill Nursing Center FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1400 John Street		
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6520 St. Helena Ave		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/29/1888	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Phila. Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 198-09-3859 A	17. INFORMANT ADDRESS Mrs. Joseph Adams, 2805 Forest View Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic CV disease Bonelets			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO years years years		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 3/13 19.67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE all m art				23B. DATE SIGNED 3/13/67	
23C. PHYSICIAN'S NAME (Type) —				23D. ADDRESS —	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/67		24C. NAME of CEMETERY or CREMATORY Meadow Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Dorsey, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967			
25B. NAME OF REGISTRAR —		25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home Dundalk, Md.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2648BIRTH NO. 67 2648

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)ARTHUR ~~LAVER~~ LAUER

2. DATE AND HOUR PRONOUNCED DEAD

March 12, 1967 1:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

00 208 South Eutaw Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

22-02
208 South Eutaw Place

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

1903
Aug. 29 1903 63-649. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

AGENT

10B. KIND OF BUSINESS OR INDUSTRY

INSURANCE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN T. LAUER

14. MOTHER'S MAIDEN NAME

ROSALIE PITTSOFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-01-5607

17. INFORMANT

ADDRESS

ELMER F. LAUER, JR. MICHAELS, MD.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 13, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3-15-67

23C. NAME of CEMETERY or CREMATORY

LODGE PARK CEM.

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1967

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

ULLRICH FUNERAL HOME, BALTO, MD.

ADDRESS

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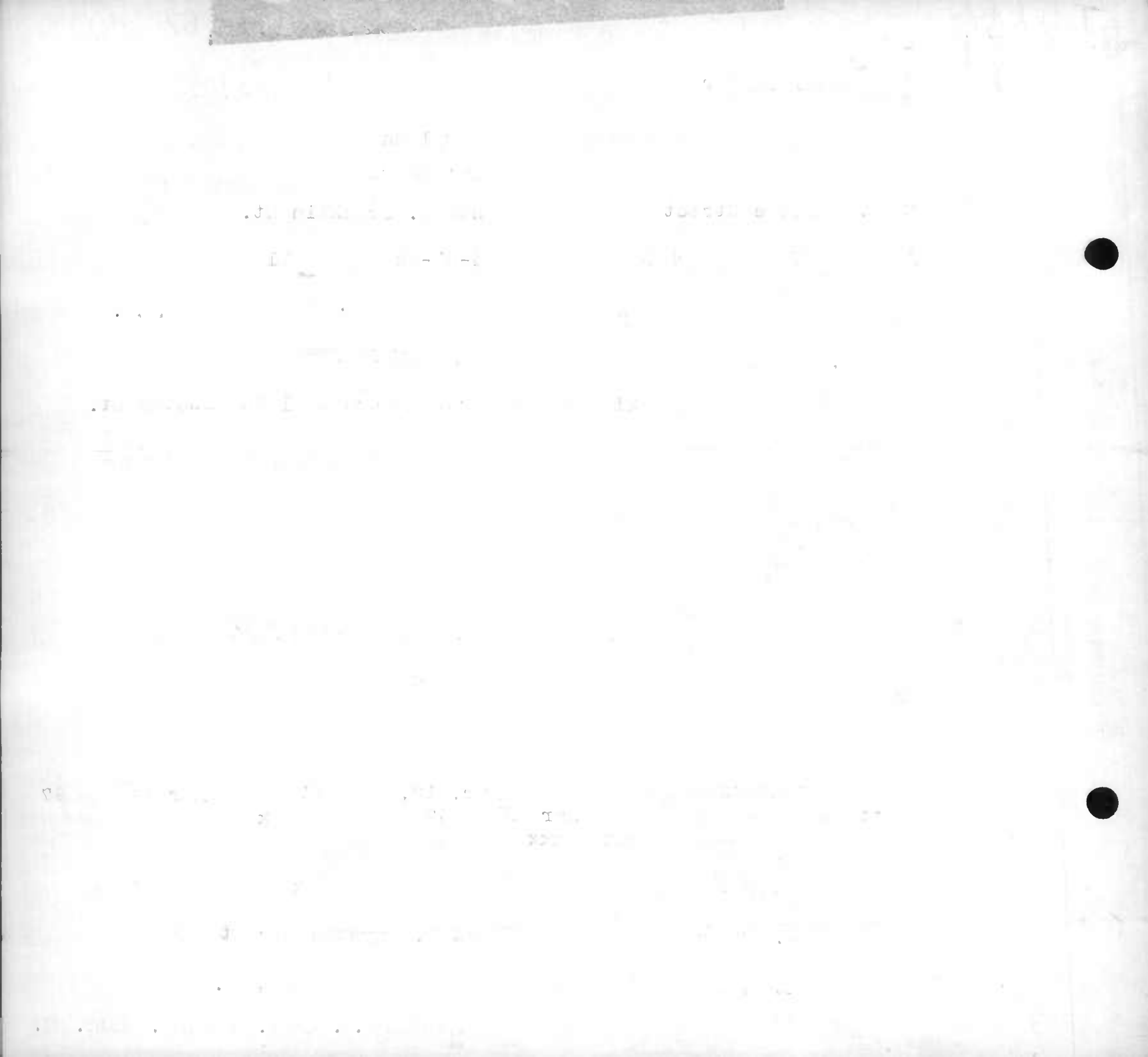
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2649		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2649	
1. NAME OF DECEASED (Type or Print) Ethel Taylor			2. DATE AND HOUR OF DEATH 15 Mar 67 11 ⁰⁰ P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1105 E. Fayette Street			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 508 W. Franklin St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH 4-27-95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE L. COLEMAN			14. MOTHER'S MAIDEN NAME AUGUSTA SCHAFER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 54 5384	17. INFORMANT ADDRESS Mrs. Anderson 1332 Webster St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, Hypertension, Generalized Atherosclerosis, Blind Eye					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) did not attended the deceased from Mar. 12, 19 67 to Mar 15 19 67 , that (I) did not last saw the deceased alive on Mar 15 19 67 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) did not (did) view the body after death.					
23A. SIGNATURE J. Hulla			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 16 Mar 67
23C. PHYSICIAN'S NAME (Type) J. Hulla			23D. ADDRESS M.D. 2214 E. Fayette Street 21231		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3/18/67	24C. NAME of CEMETERY or CREMATORY LOUDEN PARK CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1967		25B. NAME OF REGISTRAR R. A. & E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MCCULLY, F. H. 130 E. FORT AVE. BALT. MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 2650					CERTIFICATE OF DEATH			Registered No. 67 2650	
1. NAME OF DECEASED (Type or Print) Crittenden, Sarah					2. DATE AND HOUR OF DEATH 3-7-67 7:20P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. Baltimore, Maryland 21217		(If not in hospital or institution, give street address or location)			A. STATE Maryland		B. COUNTY		
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 19-02				
					D. STREET ADDRESS (If rural, give location) 1415 McCulloh Street				
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow		8. DATE OF BIRTH 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Susan Dean			ADDRESS 1415 McCulloh Street (Cousin)		
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) AS HD				CAUSE OF DEATH AS HD				INTERVAL BETWEEN ONSET AND DEATH	
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 2-21-67 19 to 3-7-67 19, that (I) (we) lost saw the deceased alive on 3-7-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. Khalig				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-8-67			
23C. PHYSICIAN'S NAME (Type) A. Khalig				23D. ADDRESS M.D. 1514 Division Street					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem PK		24D. LOCATION (City, town, or county) (State) Arbutus Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR A. Khalig		25C. FUNERAL DIRECTOR Sullivan		ADDRESS 10117 3 N. Arlington Ave			

MAR 20 1967

A 2 H D

Generalized Adenovirus

1. 1. 1. 1.

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W-514

67 2651

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2651

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT WIMPLING

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1967

2:08 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)43
99 South Baltimore General Hospital (DOA)4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

109 S. Carey Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept 5 1923

9. AGE (in years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Inc. Ellicott

10B. KIND OF BUSINESS OR INDUSTRY

Ellicott Machine Shop

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John P. Wimpling

14. MOTHER'S MAIDEN NAME

Clara M. Regler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL
SECURITY NO.

216-12-9146

17. INFORMANT

Mrs. Clara M. Wimpling, 109 S. Carey St.

ADDRESS

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Crushing injuries of thorax
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? (Yes or No)
No21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

factory

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Ellicott Machine Inc. 1611 Bush St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3/17/67 2:00 P.

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Caught between
housing and gears of boring machine

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/21/67

23C. NAME of CEMETERY or CREMATORY

Green Redeemer

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

John J. Conway & Son Inc. 901 Hollins St.

ADDRESS

13 = 207 x 2

13 = 207 x 2

13 = 207 x 2

13 = 207 x 2

13 = 207 x 2

Charles J. Fox

4/1/11

13 = 207 x 2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>56-48-12</u>	
BIRTH NO. <u>67 2652</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>Kennedy, Adele Shortt</u>				2. DATE AND HOUR OF DEATH <u>March 15, 1967</u> <u>11 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hosp.</u>				A. STATE <u>Maryland</u>			
<u>33rd & Calvert Sts. Balto. MD. 21218</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>13-07</u>			
				D. STREET ADDRESS (If rural, give location) <u>St. Mary's Roland View Towers</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED NEVER MARRIED <u>WIDOWED</u> <u>DIVORCED</u> (specify)		8. DATE OF BIRTH <u>May 13, '92</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never employed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James M. Shortt</u>				14. MOTHER'S MAIDEN NAME <u>Martha Stuhm</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT (son) <u>Donald S. Kennedy</u> ADDRESS <u>15 Tenbury Road</u> <u>21093</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD.</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS & 1/2</u>			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1967</u> 19 <u>67</u> to <u>March 15, 1967</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 15, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sang Kyun Shin</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>March 15, 1967</u>			
23C. PHYSICIAN'S NAME (Type) <u>Edwin Berstock</u> M.D.				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/18/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Old Frederick Rd, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1967</u>		25B. NAME OF REGISTRAR <u>P. B. E. Finkbeiner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Augustin E. Donovan - 3818 Roland Ave</u>			

February, 1912

March 1912

11

Memphis

Baltimore

St. Mary's Roman Church

St. Mary's Roman Church

May 13, 1912

March

W

H

Notes compiled

James M. Shortt

Baltimore

March 24

St. Mary's Roman Church

St. Mary's Roman Church

51073

St. Mary's Roman Church

A 200

March 12, 1912

March 12, 1912

Edwin Berstock

Edwin Berstock

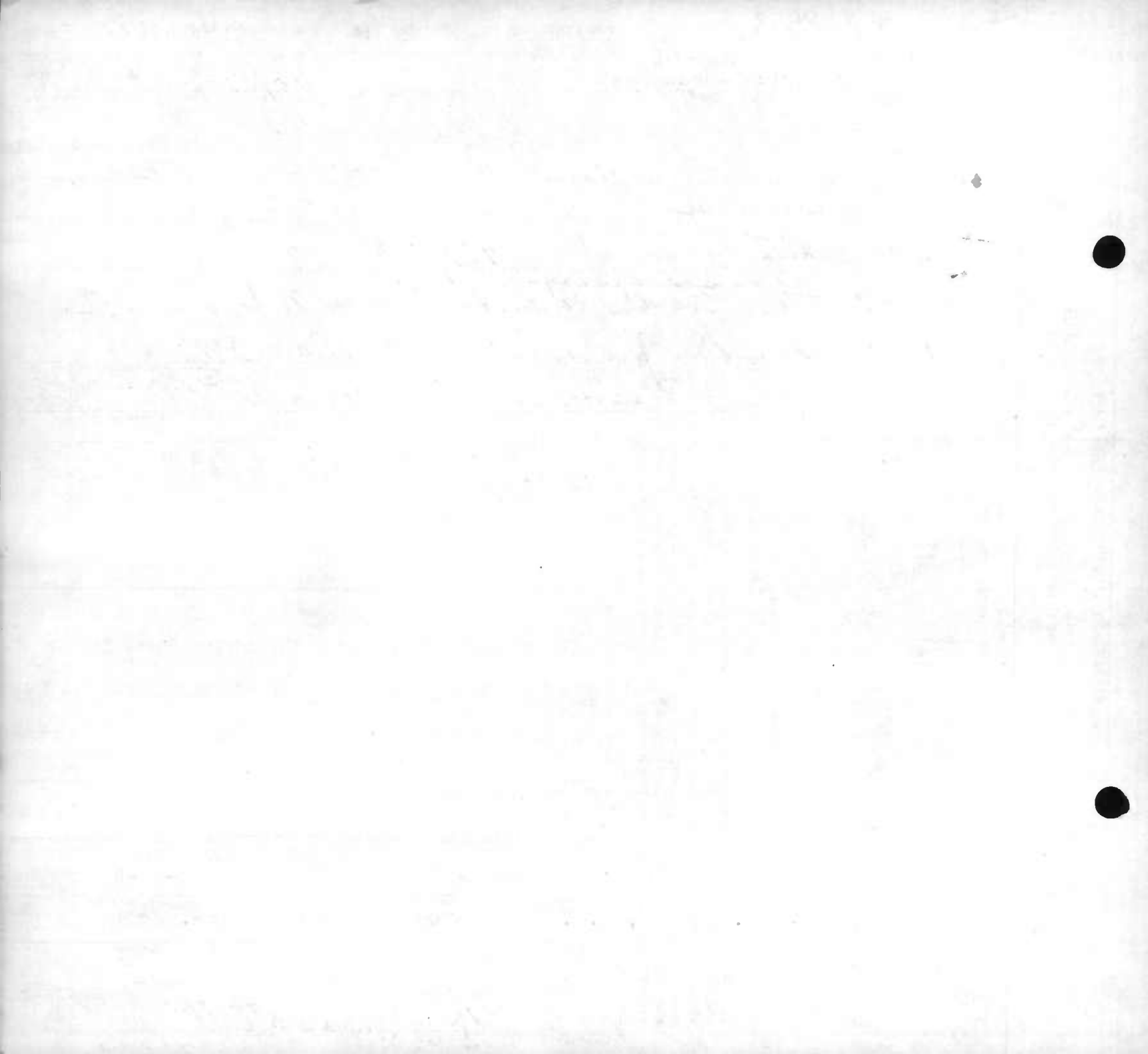
X

March 12, 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2653		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2653	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Charles Frederick Josenhans			2. DATE AND HOUR OF DEATH 3/16/1967 10:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines 2525 W. Belvidere Ave Baltimore Md			A. STATE B. COUNTY Maryland 28-41		
5. SEX male			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207		
6. RACE white			D. STREET ADDRESS (If rural, give location) 3617 Ferndale Ave		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed			8. DATE OF BIRTH 4/7/1887		
9. AGE (In years last birthday) 79			10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meat cutter			11. BIRTHPLACE (State or foreign country) Baltimore Md		
10B. KIND OF BUSINESS OR INDUSTRY Schludersberg-Hurdle Co. Inc			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frederick Julius Josenhans			14. MOTHER'S MAIDEN NAME Mary Cecelia J. J. J. J.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-14-1828		
17. INFORMANT V. Charles Rinaldo			ADDRESS att. W. Preston St. Baltimore Md. 21201		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Myocardial Infarction Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar 2 19 67 to Mar 16 19 67, that (I) (we) last saw the deceased alive on Mar 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman, M.D.			23B. DATE SIGNED 3-16-67		
23C. PHYSICIAN'S NAME (Type) Lester N. Kolman, M.D.			23D. ADDRESS 3700 Park Heights Ave. 21215		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/1967		24C. NAME of CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION Baltimore Md		24E. NAME of REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR Harry J. Amicos	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Harry J. Amicos	
25D. ADDRESS 4204 Ridgeway Ave Baltimore Md		25E. ADDRESS 21215			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2654	
BIRTH NO. 67 2654		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH MARCH 16 TH 1967 3:00 PM.	
1. NAME OF DECEASED (Type or Print) HARDESTY JAMES HARRY		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND B. COUNTY BALTO.	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
44		D. STREET ADDRESS (If rural, give location) 29 RIGHT WING DRIVE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 01-12-1883
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years, last birthday) 84
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME JAMES HENRY HARDESTY		14. MOTHER'S MAIDEN NAME MARY A STAZEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 216-32-9488	
17. INFORMANT GERALD HARDESTY		ADDRESS 3410 SELLERS ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC BRONCHIAL ASTHMA		INTERVAL BETWEEN ONSET AND DEATH 20 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) CHRONIC CONGESTIVE HEART FAILURE (B) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE (C) 30 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-10-1967 to 3-16-1967 , that (I) (we) last saw the deceased alive on 3-16-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE FRIDTJOFUR BJORNSSON M.D.		23B. DATE SIGNED 3-16 '67	
23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON M.D.		23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/20/67	
24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Spence	
25C. FUNERAL DIRECTOR J. L. GONNELLY SONS		ADDRESS 300 MACE	

JAMES HENRY HARDESTY MARY A STEEL
 MINISTER
 WEST VIRGINIA AMERICAN
 NAME WHITE MARRIED 01-15 1883 84
 59 RIGHT WING DRIVE
 BPT TOWER
 HOSPITAL
 UNION MEMORIAL
 319

CHRONIC BRONCHIAL
 ASTHMA
 CHRONIC CONGESTIVE
 HEART FAILURE
 ARTERIO-SCLEROTIC
 CHOLELITHIASIS BILE

NO

FRIDTJOF N. BERGSON UNION MEMORIAL HOSPITAL
 3-10-07
 2-10-07
 2-10-07
 3-10-07

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

mildred Waters

2. DATE AND HOUR OF DEATH

3/16/67 4:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

827 Arneliffe Road

#21221

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

2-14-05

9. AGE (In years
lost birthday)

62

If Under 1 Yr.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SEAMSTRESS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

BENJAMIN TIPPETT

14. MOTHER'S MAIDEN NAME

JANE BEAM

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

220-30-0226

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue #21224

18. 422.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

isotia insufficient

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

arteriosclerotic cardiovascular

(C)

diabetes

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/11/67 to 3/16/67.
that (I) (we) last saw the deceased alive on 3/16/67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. J. Owllen

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

3/16/67

23C. PHYSICIAN'S
NAME (Type)

Dr. R. J. Owllen

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore 21224, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

3/18/67

24C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITH

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

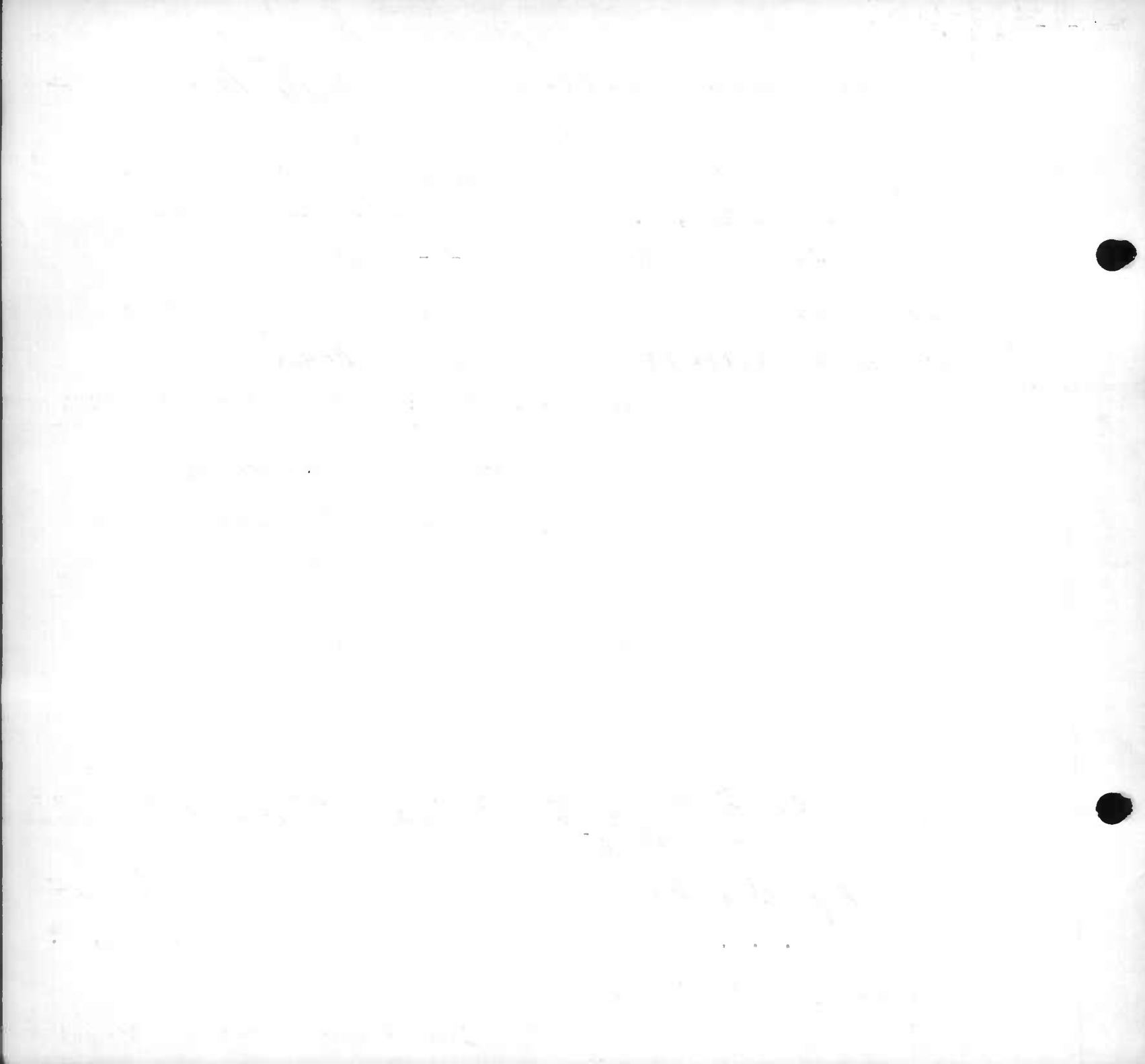
J. G. CONNELLY SONS

ADDRESS

300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No.	
BIRTH NO. 67 2656						67 2656	
M.E. CASE NO.						DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Bailey, Watha C.</i>						2. DATE AND HOUR OF DEATH <i>3/17/67 7:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hospital</i>						A. STATE <i>Maryland</i>	
(If not in hospital or institution, give street address or location)						B. COUNTY	
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 15-05</i>	
						D. STREET ADDRESS (If rural, give location) <i>2112 Presbury St.</i>	
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>1-17-1909</i>	9. AGE (In years lost birthday) <i>58</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Gas & Electric Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>George P. Bailey</i>				
14. MOTHER'S MAIDEN NAME <i>Ella G. Bailey</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				
16. SOCIAL SECURITY NO. <i>219-07-2810</i>			17. INFORMANT ADDRESS <i>Helen M. Bailey - 2112 Presbury St.</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>422.1 I</i>			CAUSE OF DEATH (A) <i>Acute Pulmonary Edema</i> DUE TO (B) <i>ASCD</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i> <i>1) Emphysema</i> <i>2) Uremia - 2° to pyelitis and/or arteriosclerosis</i> <i>3) Possible CVA</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/16/67</i> 19 to <i>3/17/67</i> 19, that (I) (we) lost saw the deceased alive on <i>3/17/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R. Blackmon, M.D.</i>					23B. DATE SIGNED <i>3/17/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Robert C. Blackmon</i>					23D. ADDRESS <i>Lutheran Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-21-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Talbott</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law 802 Madison Ave.</i>			

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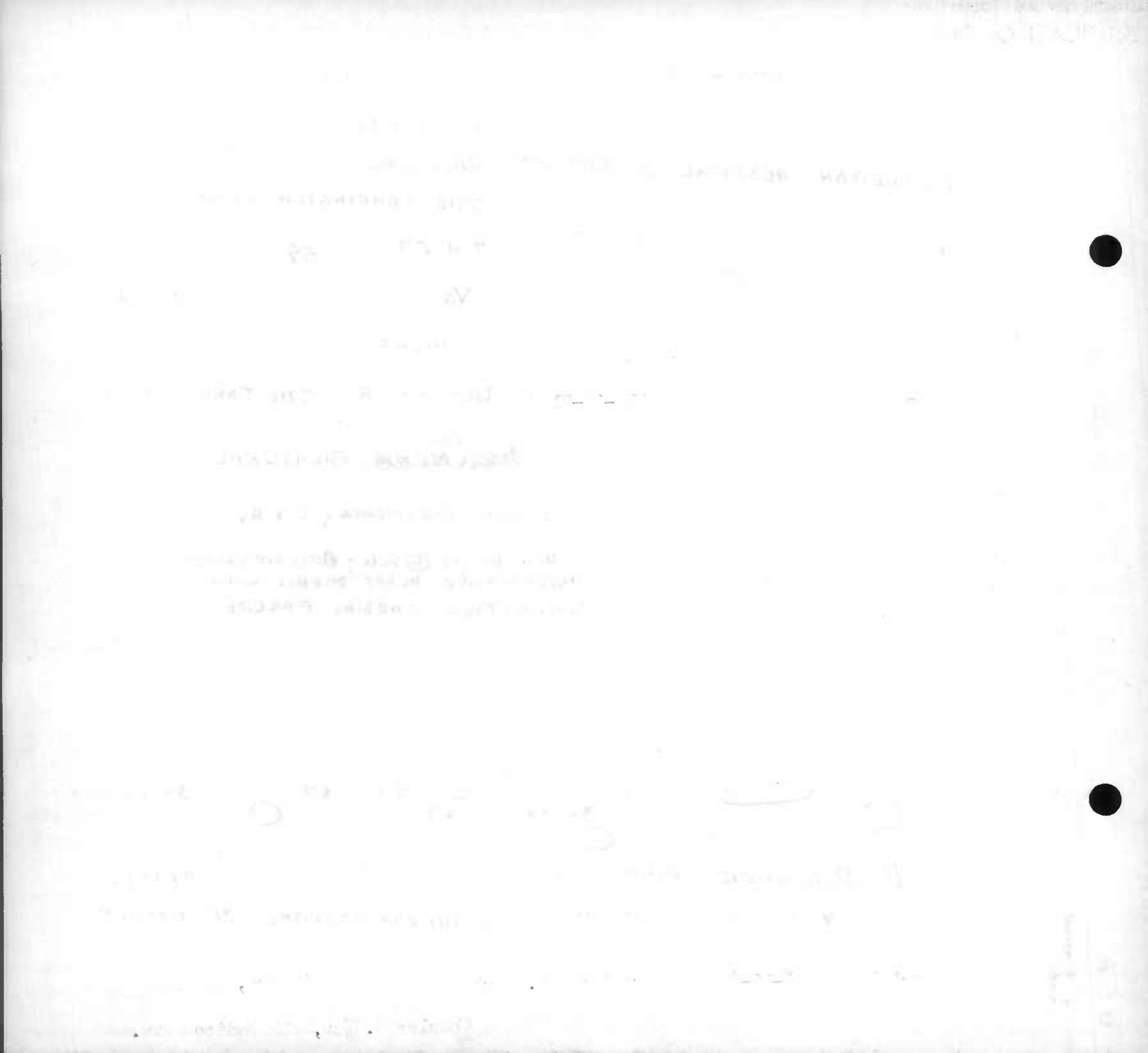
28. 10. 1914
29. 10. 1914

30. 10. 1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 R263		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2657	
BIRTH NO. 67 2657		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BURKE, LOUISE, RICHARDSON		2. DATE AND HOUR OF DEATH 3/18/67 6:25 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND 46		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-11 D. STREET ADDRESS (If rural, give location) 3716 BARRINGTON ROAD			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, <u>DIVORCED</u> (Specify)	8. DATE OF BIRTH 7-11-07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME CHARLES BEAUFORD		14. MOTHER'S MAIDEN NAME JDA HICKS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-7167		17. INFORMANT USIN ADDRESS ULYSSES RICHARDSON 3716 BARRINGTON Rd	
18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ROBEESON BILATERAL DUE TO (B) LOBAR PNEUMONIA, C.V.A. DUE TO (C) Hemiplegic Left Side: ARTERIOSCLEROTIC HYPERTENSIVE HEART DISEASE WITH CONGESTIVE CARDIAL FAILURE			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-5-1967 to 3-18-1967 , that (I) (we) last saw the deceased alive on 3-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Biswanath Pillai M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3/18/67	
23C. PHYSICIAN'S NAME (Type) V. BISWANATH PILLAI		23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-23-67	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR R. G. E. F. J. J. J.		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2658		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2658	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLARK, DEADIE		2. DATE AND HOUR OF DEATH 3-18-67 9-40 PM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3222 Westmont Av.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6-14-02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME John Williams		14. MOTHER'S MAIDEN NAME WILLIAMS Adie Mull			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-1212D		17. INFORMANT ADDRESS JOHN ROBINSON 2010 HARLEM AV	
18. 443 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ARTERIOSCLEROTIC HYPER DUE TO (B) TENSIVE CARDIOVASCULAR DUE TO (C) DISEASE WITH CONGESTIVE FAILURE		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-16-1967 to 3-18-1967, that (I) (we) last saw the deceased alive on 3-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Biswanath Pillai		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-18-67	
23C. PHYSICIAN'S NAME (Type) Y. BISWANATH PILLAI		23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.	

THE RAN HOSPITAL AT THE RAN HOSPITAL
3315 Westmont Rd

BY 10 10 10

NC

WILLIAMS

JOHN ROBINSON 3010 WILSON RD

WATER-LOVE-ROTH WYER

JOHN ROBINSON 3010 WILSON RD

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JOHN ROBINSON 3010 WILSON RD

JOHN ROBINSON 3010 WILSON RD

X

JOHN ROBINSON 3010 WILSON RD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2659		CERTIFICATE OF DEATH		Registered No. 67 2659	
1. NAME OF DECEASED (Type or Print) SINGLETON, RENA				2. DATE AND HOUR OF DEATH 3/15/67 5:20 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE				A. STATE MARYLAND, BALTIMORE					
(If not in hospital or institution, give street address or location)				B. COUNTY					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-10				D. STREET ADDRESS (If rural, give location) 4801 KIMBERLEIGH RD.					
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WID	8. DATE OF BIRTH 12/8/05		9. AGE (In years last birthday) 61		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) ALA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Bessie ?						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Roy Bates - 4801 Kimberleigh Rd.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CARDIAC ARRHYTHMIA			3 DAYS			
			(C) ASHD			1 YR			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 3/12/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 3/12 1967 to 3/16 1967 , that (1) (we) last saw the deceased alive on 3/16 1967 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Charles R. Law</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/16/67			
23C. PHYSICIAN'S NAME (Type) D. A. SPOTT		23D. ADDRESS SINAI HOSP							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.					

38-74-131B

P-400

67 2660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2660

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2660		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Neva Peele</i>		2. DATE AND HOUR OF DEATH <i>3/16/67</i> <i>10 29 PM</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 953 N. BOND STREET #21205	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH <i>11-10-16</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 50
13. FATHER'S NAME WALTER ROGERS		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME HANAH JONES	
17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE,		ADDRESS BALTIMORE, MD. 21224	
18. <i>171X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>Meta Static Carcinoma of Cervix 3 1/2 yrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/13</i> 19 <i>67</i> to <i>3/16</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/16</i> 19 <i>67</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>William A. Emerson</i>		23B. DATE SIGNED <i>3/16/67</i>	
23C. PHYSICIAN'S NAME (Type) DR. WILLIAM A. EMERSON		23D. ADDRESS #21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3-21-67	24C. NAME of CEMETERY or CREMATORY Mt. Calvary	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967	25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		Registered No. 67 2661	
BIRTH NO. 67 2661		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 3/17/67 12:45 P.M.	
1. NAME OF DECEASED (Type or Print) EUGENE L. FLIPPIN			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp 48		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-11 D. STREET ADDRESS (If rural, give location) 4403 Lindenwood Rd (21218)	
5. SEX M	6. RACE N W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/09/92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician		10B. KIND OF BUSINESS OR INDUSTRY radiology	9. AGE (in years last birthday) 74
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Mays Flippin		14. MOTHER'S MAIDEN NAME Marion, CORA LEE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 218-42-0068	17. INFORMANT wife
18. 5-27-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Cor Pulmonale		INTERVAL BETWEEN ONSET AND DEATH —	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Obstructive Airways Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/16 19 67 to 3/17 19 67 , that (I) (we) last saw the deceased alive on 3/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert Goldner		23B. DATE SIGNED 3/17/67	
23C. PHYSICIAN'S NAME (Type) Robert Goldner		23D. ADDRESS 527 Linden Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 3-20-67	
24C. NAME of CEMETERY or CREMATORY Horrairie Mausoleum		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Goldner	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.		25D. ADDRESS 1217 St. Paul St. (21202)	

BIRTH NO. 67 2662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2662

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Pius Kline

2. DATE AND HOUR PRONOUNCED DEAD

3-18-67

3:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

1900 Tolson Ave

5. SEX

m

6. RACE

white

7. MARRIED ~~NEVER MARRIED~~
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

May 5, 1912

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Carrolltown, Penna

12. CITIZEN OF
WHAT COUNTRY?

A.S.A.

13. FATHER'S NAME

Edwin T. Kline

14. MOTHER'S MAIDEN NAME

Lucinda Dietrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

Stevens Funeral Home

ADDRESS

Carrolltown
Penna

18.

E904.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Purulent Meningitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Sub dural hematoma

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1900 Tolson Ave

53-00

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

11-21-66 6 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

fell in home

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner H. Spitz

M.D.

DATE SIGNED

3-19-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-22-67

23C. NAME OF CEMETERY or

St. Benedict's

23D. LOCATION

(City, town, or county)

(State)

Carrolltown, Penna

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

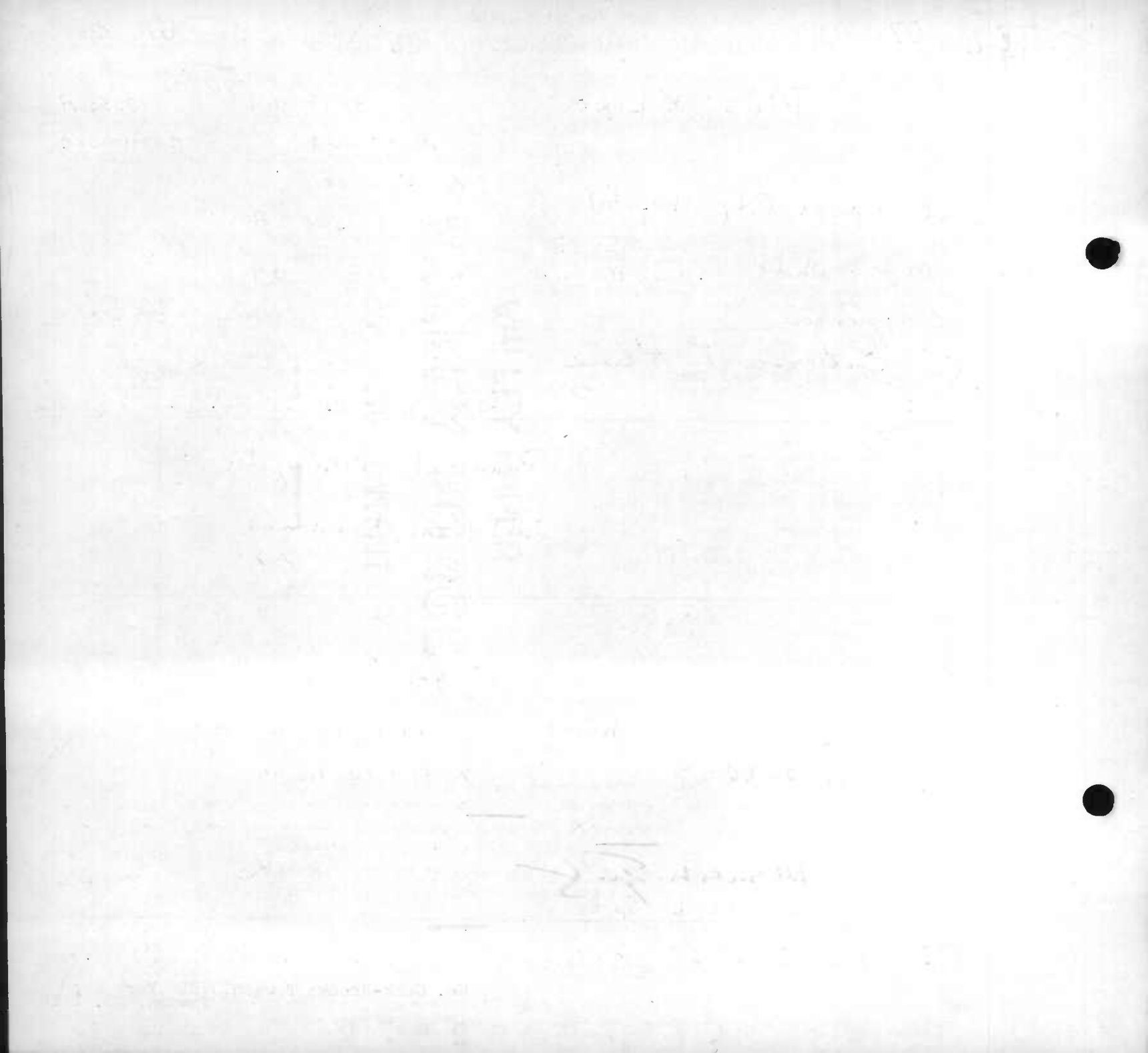
24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Towson, 1050 York Road
Towson, Md. 21204

MAR 20 1967

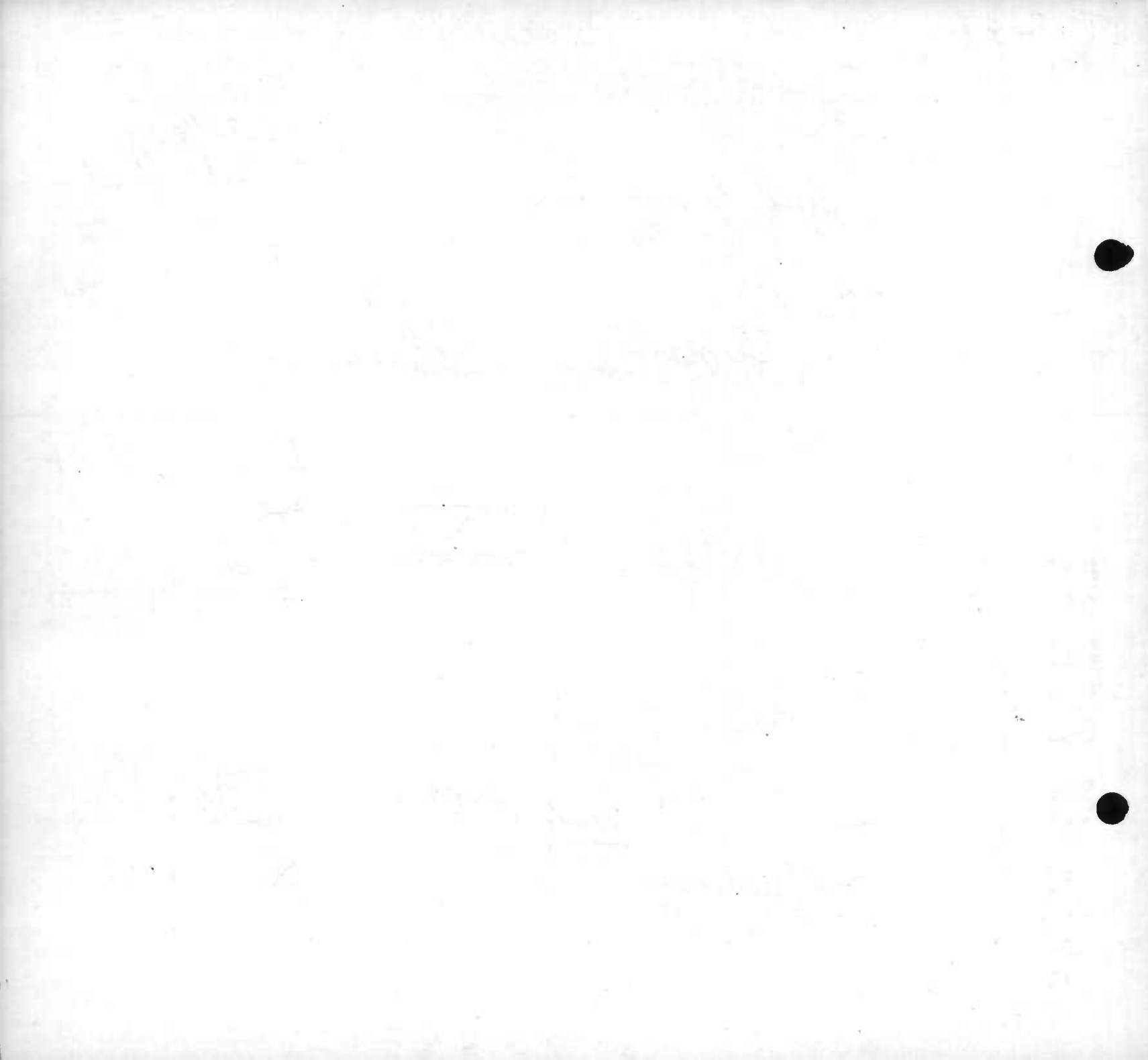
1585-4125 00002670



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

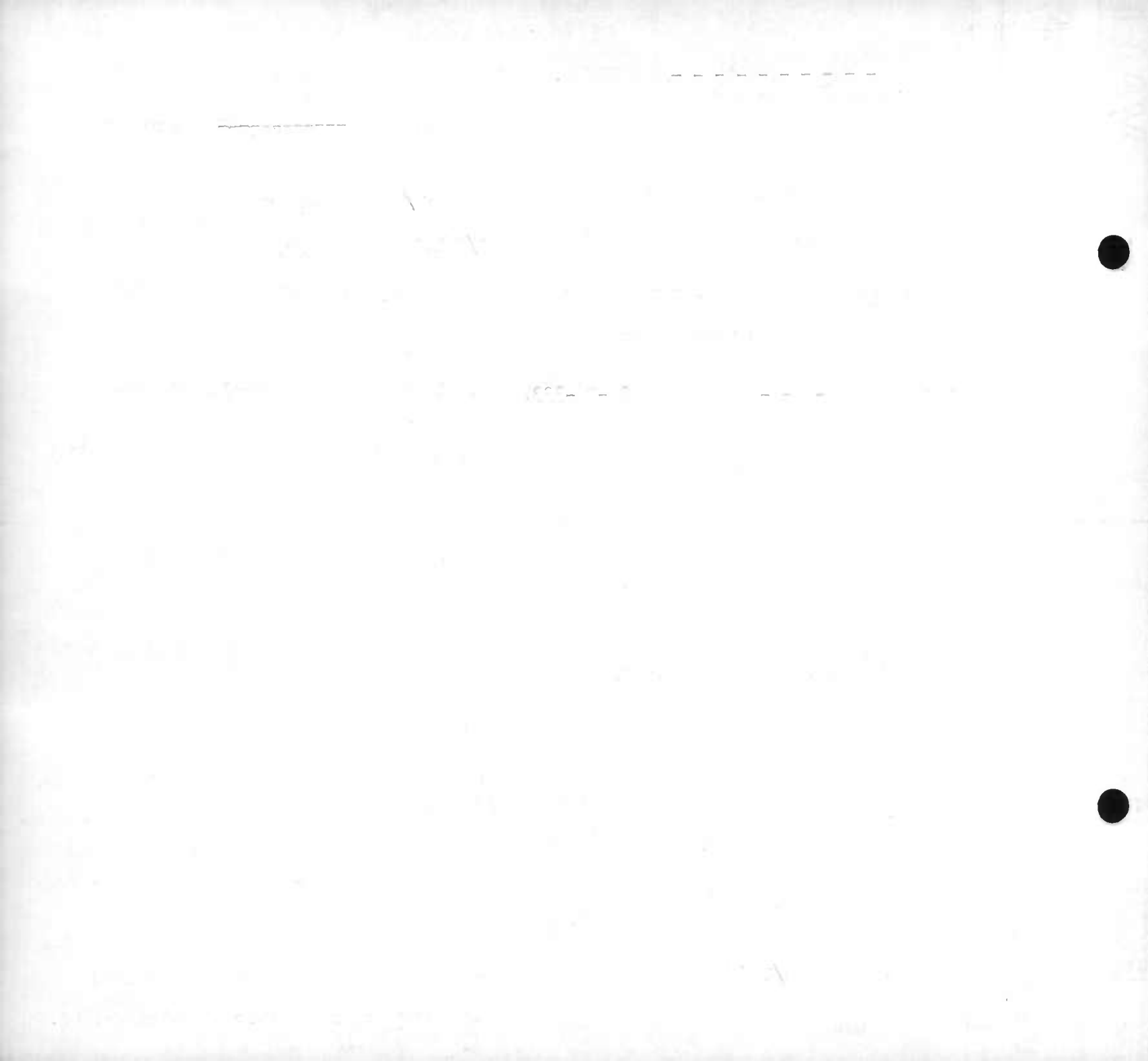
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2663	
BIRTH NO. 67 2663		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Francis Thomas</i>		2. DATE AND HOUR OF DEATH <i>3/16/67 600 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <i>2403 Estelle Ave. Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt Md 53-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland General Hospital</i>		D. STREET ADDRESS (If rural, give location)			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>6/25/89</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months; Days If Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Pa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Jesse Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Garber</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <i>570.21</i>		CAUSE OF DEATH (A) DUE TO <i>Septicemia & shock - small bowel infarction</i> (B) DUE TO <i>Peritonitis</i> (C) <i>due to superior mesenteric artery thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/15/67</i> 19 to <i>3/16/67</i> 19, that (I) (we) last saw the deceased alive on <i>3/16/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. J. Baldwin</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/16/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Brian Baldwin</i>		M.D. 23D. ADDRESS <i>Maryland Gen Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-20-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Alquippa Pennsylvania</i>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR ADDRESS <i>Wm Cook-Brooks Inc. 1217 St. Paul St</i>		25D. NAME OF REGISTRAR <i>Wm Cook-Brooks Inc.</i>		25E. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 2664				
BIRTH NO. 67 2664					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) LORD, AWDRY L.					2. DATE AND HOUR OF DEATH 3/15/67 7²⁵ P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSP					A. STATE Md.				
					B. COUNTY Dorchester				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cambridge				
					D. STREET ADDRESS (If rural, give location) 601 WILLIAM ST				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 2/5/1916	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10B. KIND OF BUSINESS OR INDUSTRY Library & Apts.		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Leonard Lord				14. MOTHER'S MAIDEN NAME Ethel Grey					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-26-3337		17. INFORMANT ADDRESS Mr. Elwood A. Lord, Laurel, Delaware					
18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) BRAIN TUMOR DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 15 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 7/13/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED B.T.		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3/13/67 to 3/15/67 , that (I) (we) last saw the deceased alive on 3/15/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/15/67		
23C. PHYSICIAN'S NAME (Type) ARNOLDO SCHUPAK M.D.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/67		24C. NAME of CEMETERY or CREMATORY East New Market Cemetery		24D. LOCATION (City, town, or county) (State) East New Market, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2665	
60 B-2		67 2665		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Irene S. Becker			2. DATE AND HOUR OF DEATH March 15, 1967 11:40 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2606 Manhattan Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-19 D. STREET ADDRESS (If rural, give location) 2606 Manhattan Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 14, 1917	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Benjamin Shuster			14. MOTHER'S MAIDEN NAME Lena Talk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mr. Irving Becker, 2606 Manhattan Avenue	
18. 15-4X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of rectum with widespread metastases			INTERVAL BETWEEN ONSET AND DEATH 7 mos.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1967 to March 15, 1967 , that (I) (we) last saw the deceased alive on March 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein			23B. DATE SIGNED 3/16/67		
23C. PHYSICIAN'S NAME (Type) Dr. Marvin Goldstein			23D. ADDRESS 6001 Park Heights Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/67		24C. NAME OF CEMETERY or CREMATORY Beth El Memorial Park	
24D. LOCATION (City, town, or county) (State) Randallstown, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

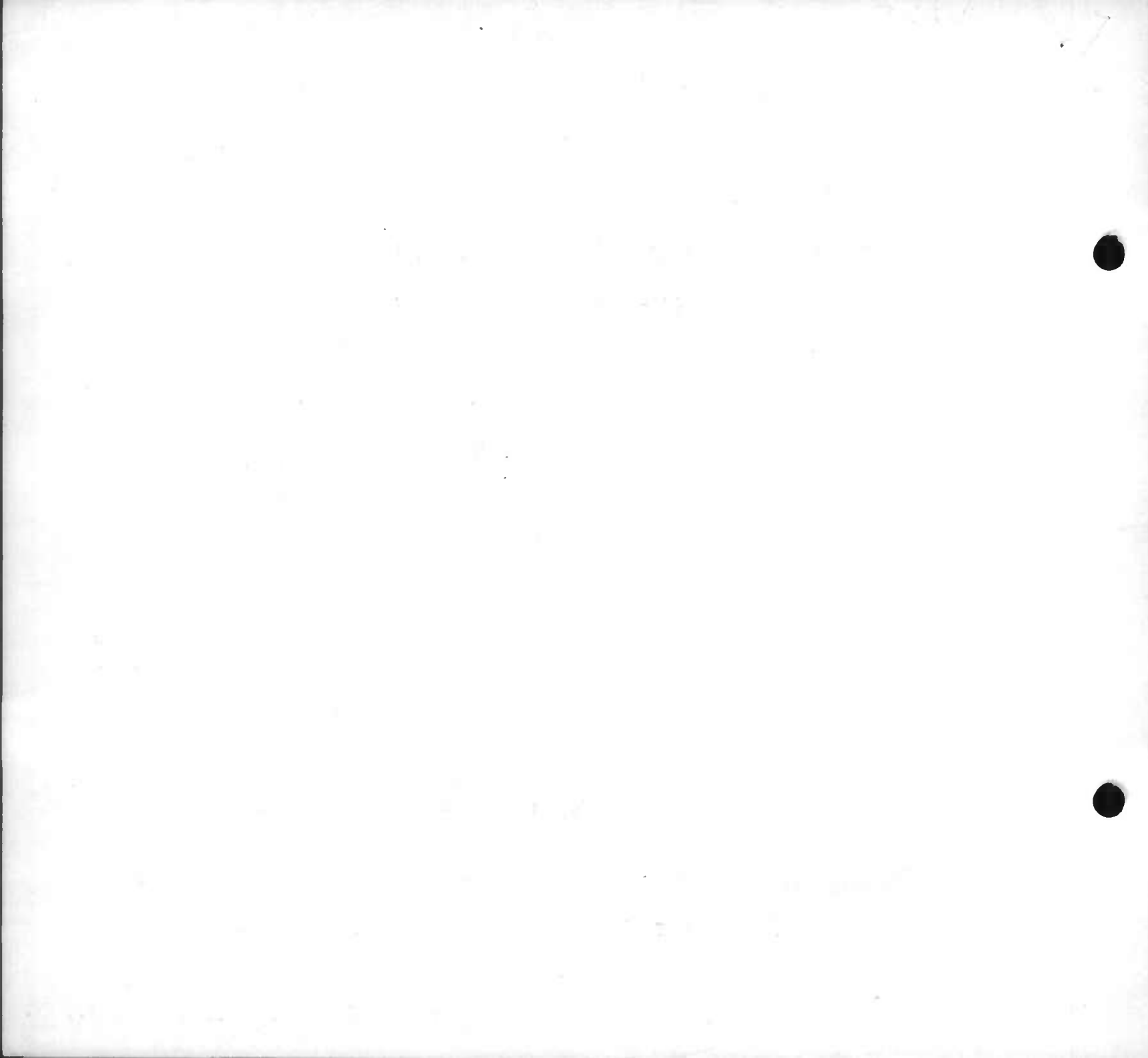
BIRTH NO. 67 2666		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2666	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Schlechter Albert Louis			2. DATE AND HOUR OF DEATH 3/15/67 4:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAL HOSPITAL OF BALTIMORE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY MURKIN C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-10 D. STREET ADDRESS (If rural, give location) 3813 W. COLDSPRING LANE		
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH REDACTED	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXX Salesman Children's Wear		10B. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13. FATHER'S NAME Eleazer Schlechter			14. MOTHER'S MAIDEN NAME Ann ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. W. 1 Army		16. SOCIAL SECURITY NO. 189-07-6638		17. INFORMANT Mrs. Rose Schlechter, 3813 W. Cold Spring Lane	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction, massive ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCD			CAUSE OF DEATH (A) Acute Myocardial Infarction, massive (B) ASCD (C) _____		
INTERVAL BETWEEN ONSET AND DEATH 3 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/15 125 PM 19 67 to 3/15 4 PM 19 67 , that (I) (we) last saw the deceased alive on 3/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. B. Samson - Corvera, M.D.				23B. DATE SIGNED 3/15/67	
23C. PHYSICIAN'S NAME (Type) E. B. SAMSON - CORVERA		23D. ADDRESS Sinal Hospital of Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/67		24C. NAME of CEMETERY or CREMATORY Hebrew Friendship	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR REDACTED		25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.	



FUNERAL DIRECTOR: IMPORTANT

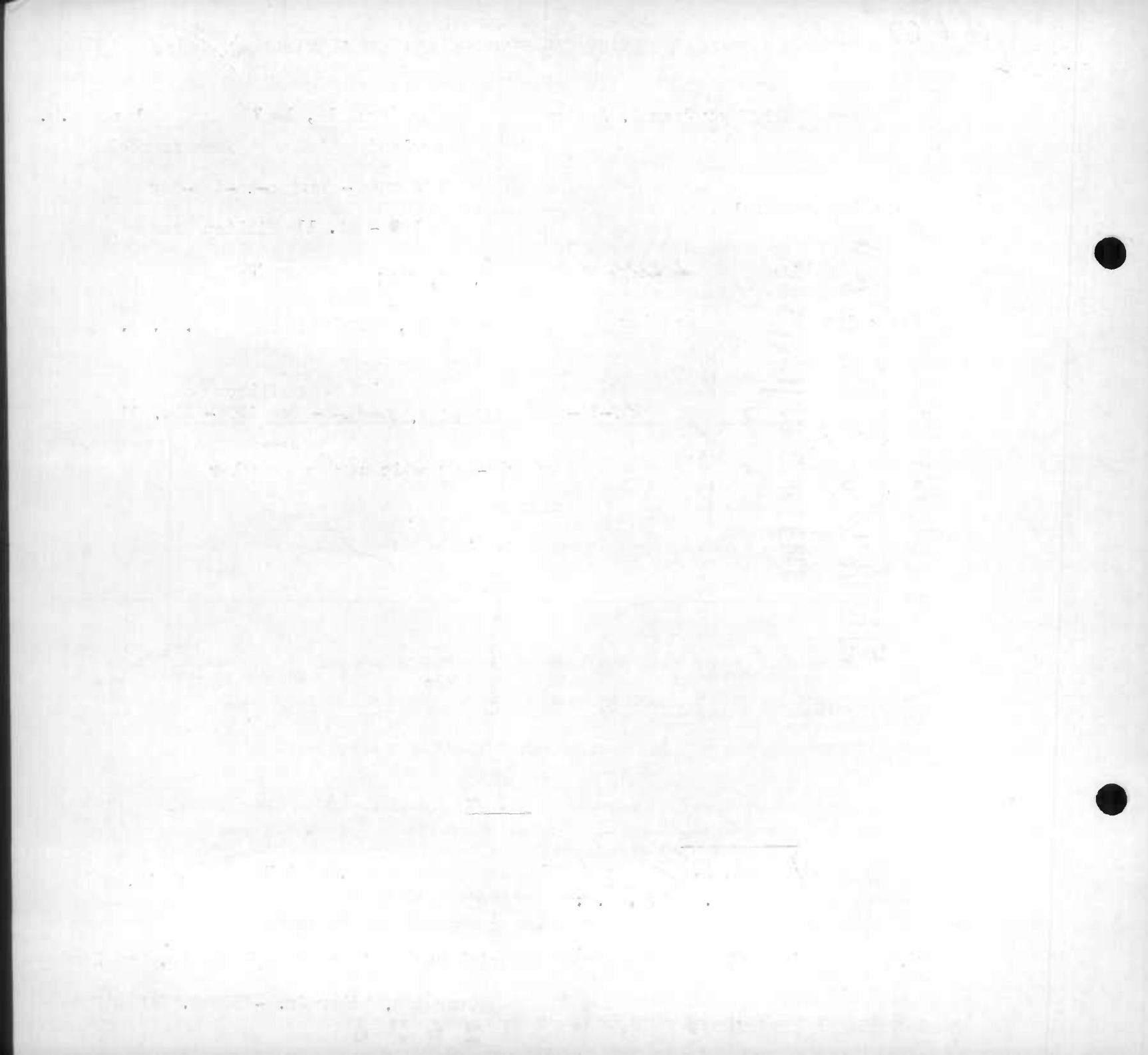
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-165 BIRTH NO. 67 2667				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2667	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HYMAN ABRAMSON		MARCH 15, 1967 3:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND			
00 7009 WALLIS AVENUE				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 22 20	
				D. STREET ADDRESS (If rural, give location)		7009 WALLIS AVENUE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
MALE	WHITE	WIDOWED	SEPT. 19, 1882	84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
REAL ESTATE			SELF-EMPLOYED		LITHUANIA		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
EDWARD ABRAMSON			BERTHA WEINER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO			UNKNOWN		MR. HARRY ABRAMSON, 7007 WALLIS AVENUE		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Anterior Myocardial Infarction	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1966 to 3/15 1967, that (I) (we) last saw the deceased alive on 3/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
DR. LEONARD LISTER						3/15/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				PARK TOWERS APARTMENTS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		3/16/67		HAR SINAI		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 20 1967		L. B. E. Taylor, Jr.		SOL LEVINSON & BROS. INC.,		6010 REIST., RD.	



1
J-236

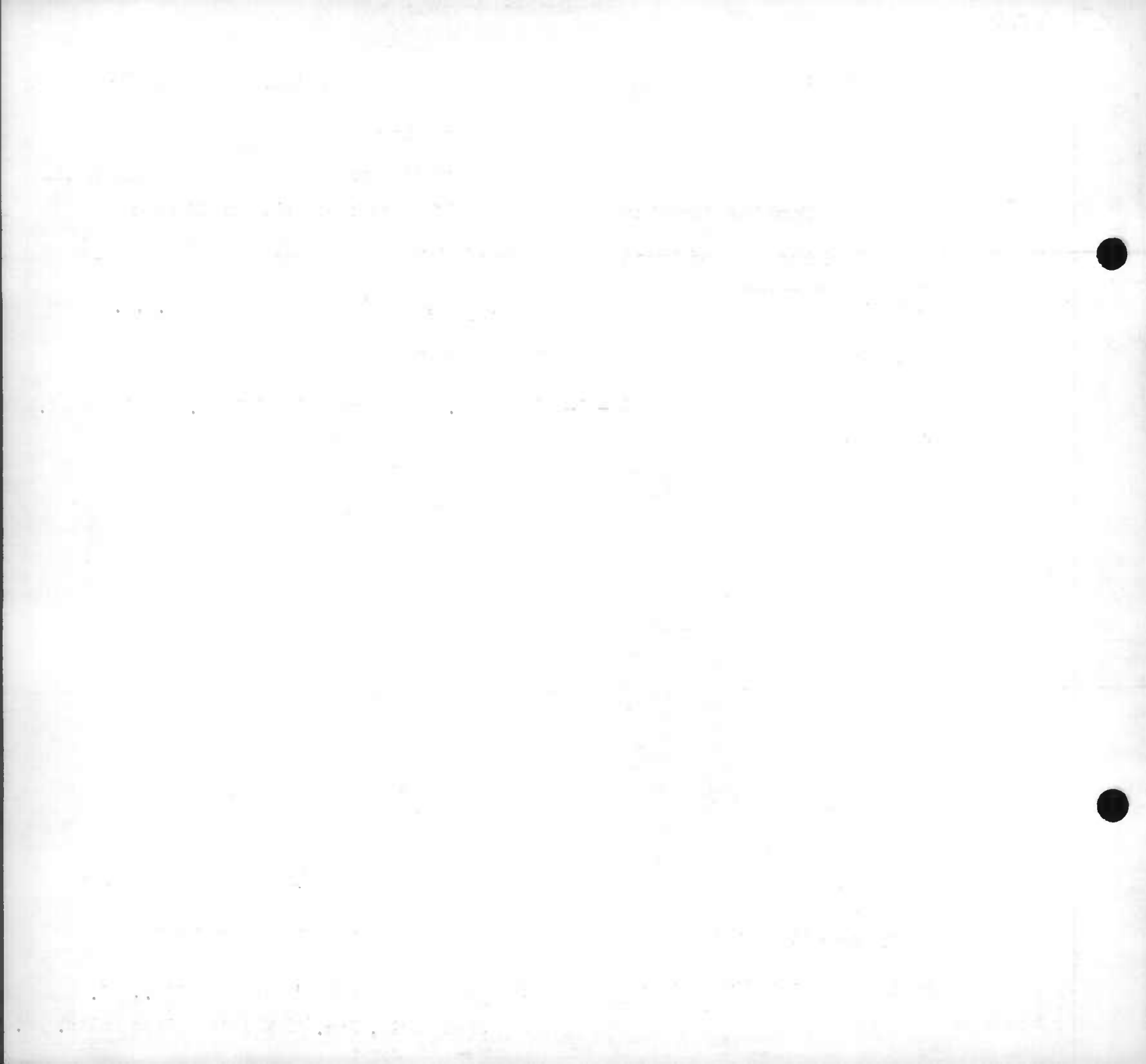
BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 2668		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2668	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Jean JESTER or Jean C. Jester		2. DATE AND HOUR PRONOUNCED DEAD March 19, 1967 12:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena - Venice-on-the-Bay 52-00 D. STREET ADDRESS (If rural, give location) Bx 120 - Rt. 11 Hilltop Road	
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 14, 1921
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Cashier	9. AGE (In years last birthday) 46
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Clements		14. MOTHER'S MAIDEN NAME May Orndorff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-14-5428	
17. INFORMANT Roland E. Jester - Box 120E- Rte. 11		ADDRESS Hilltop Road	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic cardio vascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 19, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/22/67	
23C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park		23D. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland	
24A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		24B. NAME OF REGISTRAR Robert E. Taylor	
24C. FUNERAL DIRECTOR George A. Weber Jr. - 705 S. Ann Street		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

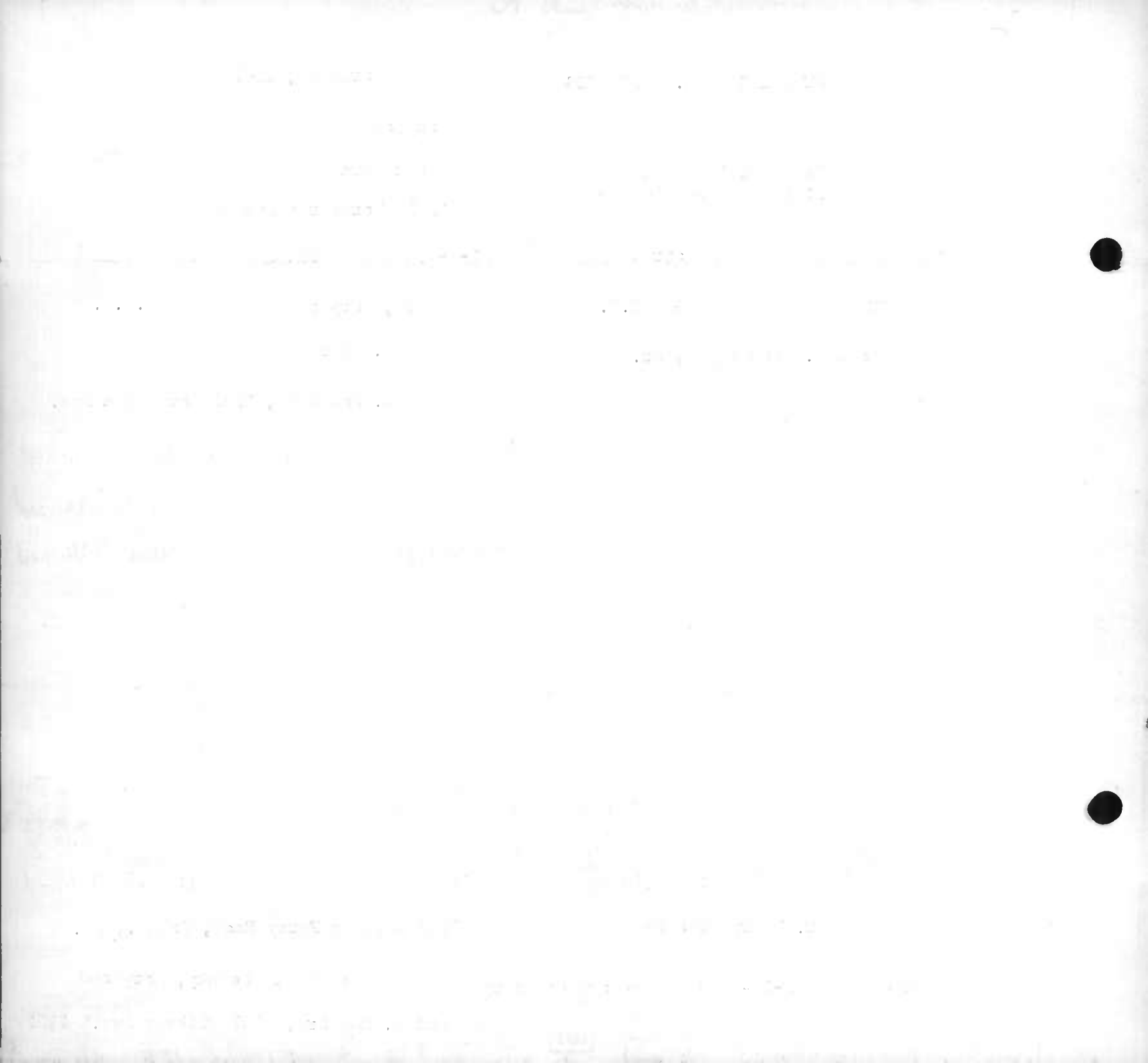
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2669</u>	
BIRTH NO. <u>67 2669</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Louis Cohen</u>		2. DATE AND HOUR OF DEATH <u>8:09 am</u> <u>3/17/67</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1729 East Baltimore Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5/ /82</u>	9. AGE (In years lost birthday) <u>84</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Latvia, Russia</u>	
13. FATHER'S NAME <u>Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Sonja</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-03-6538A</u>		17. INFORMANT <u>Mrs. Sara Tarasevich</u> ADDRESS <u>1729 E. Baltimore St.</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>MI</u> DUE TO (B) <u>ASCD, CAPSULE</u> DUE TO (C) <u>MI</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/16/67</u> 19 <u>67</u> to <u>3/17/67</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>3/17</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. Ismail Beigi</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/17/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>F. Ismail Beigi</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/19/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mikro Kodesh Beth Israel</u>	
24D. LOCATION (City, town, or county) (State) <u>Bowley's Lane Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Jack Lewis, Inc. 2100 Eutaw Place Balto., Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2670				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2670	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print)				STERLING L. SAUMENIG		March 16, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
90 Hood Nursing Home				5213 Edmondson Avenue		Maryland			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male				White		Married		2-6-1908	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Clerk				B & O R.R.		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Wallace L. Saumenig, Sr.				Alice E. Sterling					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
						Blanche L. Saumenig, 2565 Marbourne Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				undetermined	
ANTECEDENT CAUSES				(B) DUE TO				undetermined	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO				undetermined	
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from				19 66 to		March 14 19 67			
that (I) (we) last saw the deceased alive on				March 14 19 67		and that in (my) (our) opinion death occurred on the date		3.16.67	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		March 17, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Dr. Henry Armanas				2919 Hollins Ferry Road, Balto., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				3-20-1967		Woodlawn Cemetery		Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 20 1967				Howard H. Hubbard		4107 Wilkens Ave.		21229	



H-623

67 2671

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 2671

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KENNETH R. HORST

2. DATE AND HOUR PRONOUNCED DEAD

3-15-67

1:45 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4214 Maryland Place

21229

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10-20-1916

9. AGE (In years
lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Filling Sta. Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Russell O. Horst

14. MOTHER'S MAIDEN NAME

Florence Kendall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W II

16. SOCIAL
SECURITY NO.

215-07-9900

17. INFORMANT

ADDRESS

Mrs. Edith R. Horst, 4214 Maryland Place 21229

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carbon monoxide poisoning
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Park

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Patapsco State Park

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour) (Minute)

App. 12:30
PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Found in car with motor
running - garden hose through rear window
and in mouth

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-15-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-18-1967

23C. NAME of CEMETERY or CREMATORY

Rest Haven Chapel

23D. LOCATION

(City, town, or county)

Hagerstown, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 20 1967

Robert E. Fisher

Howard H. Hubbard, 4107 Wilkens Ave. 21229

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 2672					CERTIFICATE OF DEATH					Registered No. 67 2672				
1. NAME OF DECEASED (Type or Print) DORA ESTELLA DEUCHLER										2. DATE AND HOUR OF DEATH March 14, 1967				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2227 Washington Blvd.										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2227 Washington Blvd.				
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 6-16-1878		9. AGE (In years lost birthday) 88		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Bealefeld						14. MOTHER'S MAIDEN NAME Madalena								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-48-3724		17. INFORMANT Mr. George H. Deuchler, Jr.				ADDRESS 3302 Ellerslie Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4221 + 210X (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) Acute Congestive Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Arterio sclerosis Cardiovas. disease Diabetes Mellitus.										CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II														
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from 1965 to March 14 19 67 , that (I) (we) last saw the deceased alive on March 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Geo S M Kieffer										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED March 18 67		
23C. PHYSICIAN'S NAME (Type) Dr. George S.M. Kieffer				M.D.		23D. ADDRESS 1010 Leeds Avenue, Balto, Md.								
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland						
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.								

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 2673					67 2673					
BIRTH NO.					Registered No.					
1. NAME OF DECEASED (Type or Print) Catherine C. Engelhardt					2. DATE AND HOUR OF DEATH 3-12-1967 5.45 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1510 Pentridge Road					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1510 Pentridge Road 21212					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-10-1898	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Rudolph Walter					14. MOTHER'S MAIDEN NAME Lena Gesser					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-12-4809		17. INFORMANT Mr Herbert Engelhardt 1510 Pentridge Rd					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMATOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CA. OF OVARY					INTERVAL BETWEEN ONSET AND DEATH 21					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II										
19A. DATE OF OPERATION 11-25-66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploration			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 11-15 19 66 to death 19 66 and that (I) (we) lost saw the deceased alive on 12/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Michele Cerino					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 3/14/67		
23C. PHYSICIAN'S NAME (Type) MICHELE CERINO					23D. ADDRESS M.D. 2919 St. Paul St					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-1967		24C. NAME of CEMETERY or CREMATORY Moreland Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Lazarus Funeral Home			ADDRESS 2401 Belair Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2674		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 SP2674	
M.E. CASE NO.		CERTIFICATE OF DEATH		G S	
1. NAME OF DECEASED (Type or Print) NORMAN R. HAINES		2. DATE AND HOUR OF DEATH 3/15/67		2 30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY Hospital Balto Md		A. STATE B. COUNTY PENNSYLVANIA			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) HANOVER V-35			
		D. STREET ADDRESS (If rural, give location) 126 THIRD ST.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE-NM	8. DATE OF BIRTH 2/7/13	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chain Marker	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GLENNVILLE Pa	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME LUTHER HAINES		14. MOTHER'S MAIDEN NAME JOHANNA SMITH HAINES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 163-38-1308		17. INFORMANT PH Clerk ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) CARCINOMA OF BLADDER DUE TO METASTASIS to small bowel, Omentum, & Liver; Bowel obstruction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(B) DUE TO Secondary to Ca.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2/13/67	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/1/67 to 3/15/67, that (1) (we) lost saw the deceased alive on 3/14/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE IRVIN M. SOPHER M.D.		23B. DATE SIGNED 3/15/67			
23C. PHYSICIAN'S NAME (Type) IRVIN M. SOPHER M.D.		23D. ADDRESS University Hosp. Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-18-67	24C. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	24D. LOCATION (City, town, or county) (State) Hanover York Co. Pa		
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Sapher	25C. FUNERAL DIRECTOR Diction & Fine Funeral Home Hampstead, Md.		



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2675	
BIRTH NO. 67 2675		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARIAGIOVANNA VITALE CHRISTELLO			2. DATE AND HOUR OF DEATH March 16, 1967 9P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6526 Parnell Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21222 D. STREET ADDRESS (If rural, give location) 6526 Parnell Avenue		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10/22/1890	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy
13. FATHER'S NAME Andrea Vitale			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-09-1156B	17. INFORMANT ADDRESS Giro Christello, same as #4		
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Coronary Occlusion (B) DUE TO Diabetes Mellitus (C) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 3/15-3/16/67 10/12/55 10/12/55
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			NONE		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/12/55 19 67 to 3/16 19 67 , that (I) (was) last saw the deceased alive on 3/16/67 and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Morris A. Jacobs M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3/18/67	
23C. PHYSICIAN'S NAME (Type) Morris Jacobs, M.D.		23D. ADDRESS M.D. 1010 North Point Road, Dundalk 21222			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/67		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 2676 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2676	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HARRY E. HITCHENS			2. DATE AND HOUR OF DEATH March 14, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2613 Barclay Street		
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 29, 1890	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Ooys: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Hospital Laundry		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Elihu Jackson Hitchens		
14. MOTHER'S MAIDEN NAME Nancy Jane Jenkins			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-05-0713			17. INFORMANT A Mrs. Elizabeth Hitchens		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I acute myocardial infarction			CAUSE OF DEATH (A) DUE TO 1 day		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 6 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None			19A. DATE OF OPERATION 0		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I certify that (I) (the hospital) attended the deceased from Jan 1, 1961 to March 14, 1967 , that (I) was last saw the deceased alive on March 14, 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.		
23A. SIGNATURE Manuel Levin			23B. DATE SIGNED 3/16/67		
23C. PHYSICIAN'S NAME (Type) Dr. Manuel Levin			23D. ADDRESS 4818 Reisterstown Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-67		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR John E. Fisher		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			
ADDRESS 6500 York Rd. Baltimore, Md. 21212		V5 150-REV. 1/1/67			

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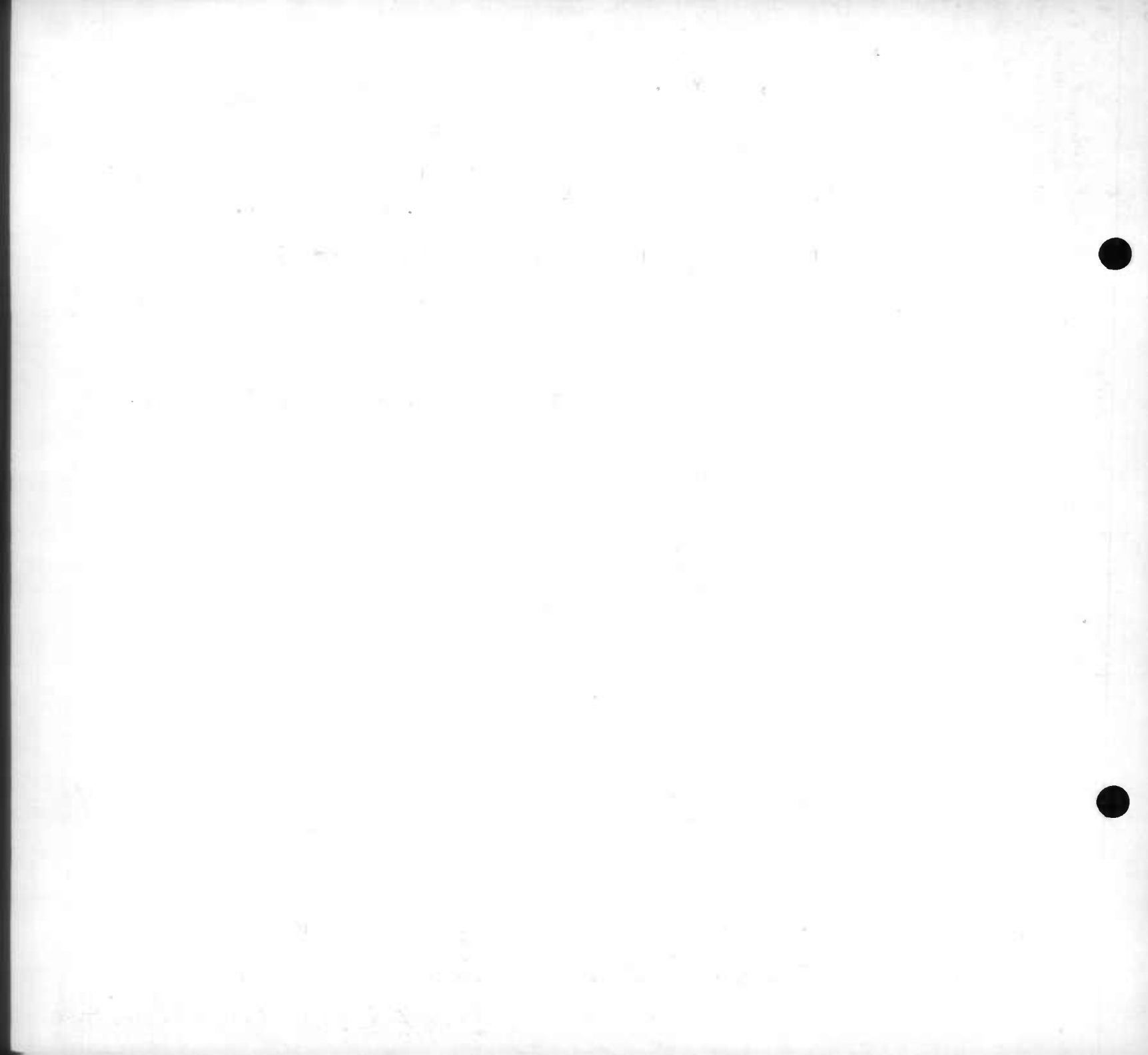
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

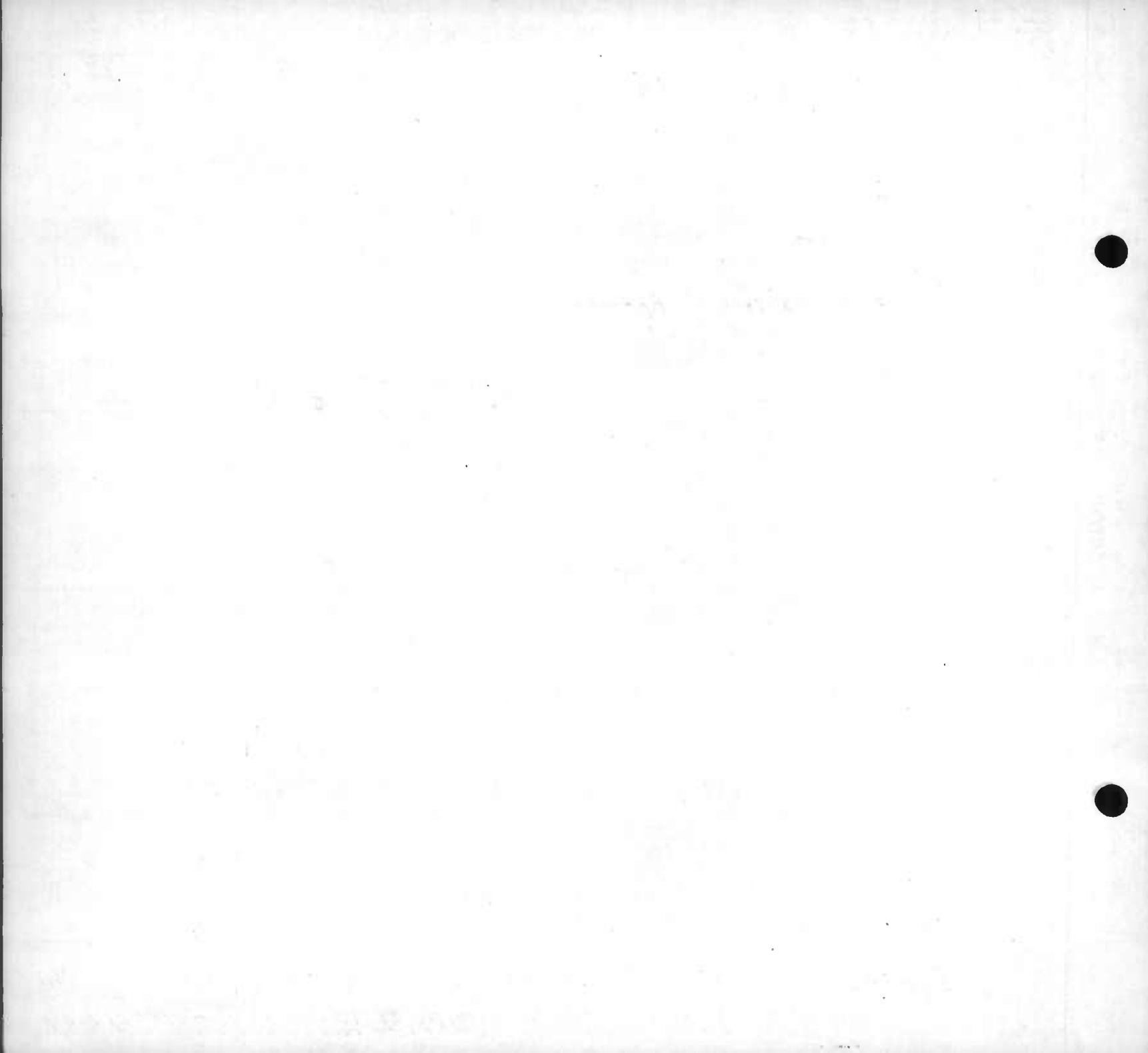
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2877	
<div style="display: flex; justify-content: space-between;"> F-54067 2877 BIRTH NO. </div>					
<div style="display: flex; justify-content: space-between;"> M.E. CASE NO. 1. NAME OF DECEASED </div>					
(Type or Print) FINLEY, MARY C.			2. DATE AND HOUR OF DEATH 3-16-67 6:10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7-61 D. STREET ADDRESS (If rural, give location) 624 N. STREEPER ST.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-02-99	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES KESKA			14. MOTHER'S MAIDEN NAME FRANCES MAXA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-32-2202B	17. INFORMANT James W. Finley 624 N. Streeper St.		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 3/9 1967 to 3/16 1967 , that (I) (we) lost saw the deceased alive on 3/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE R. Rampton				23B. DATE/SIGNED 3/16/67	
23C. PHYSICIAN'S NAME (Type) R. RAMPTON				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-67		24C. NAME OF CEMETERY or CREMATORY OAK Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Philip G. Vach	
ADDRESS 1211 Chesaco Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

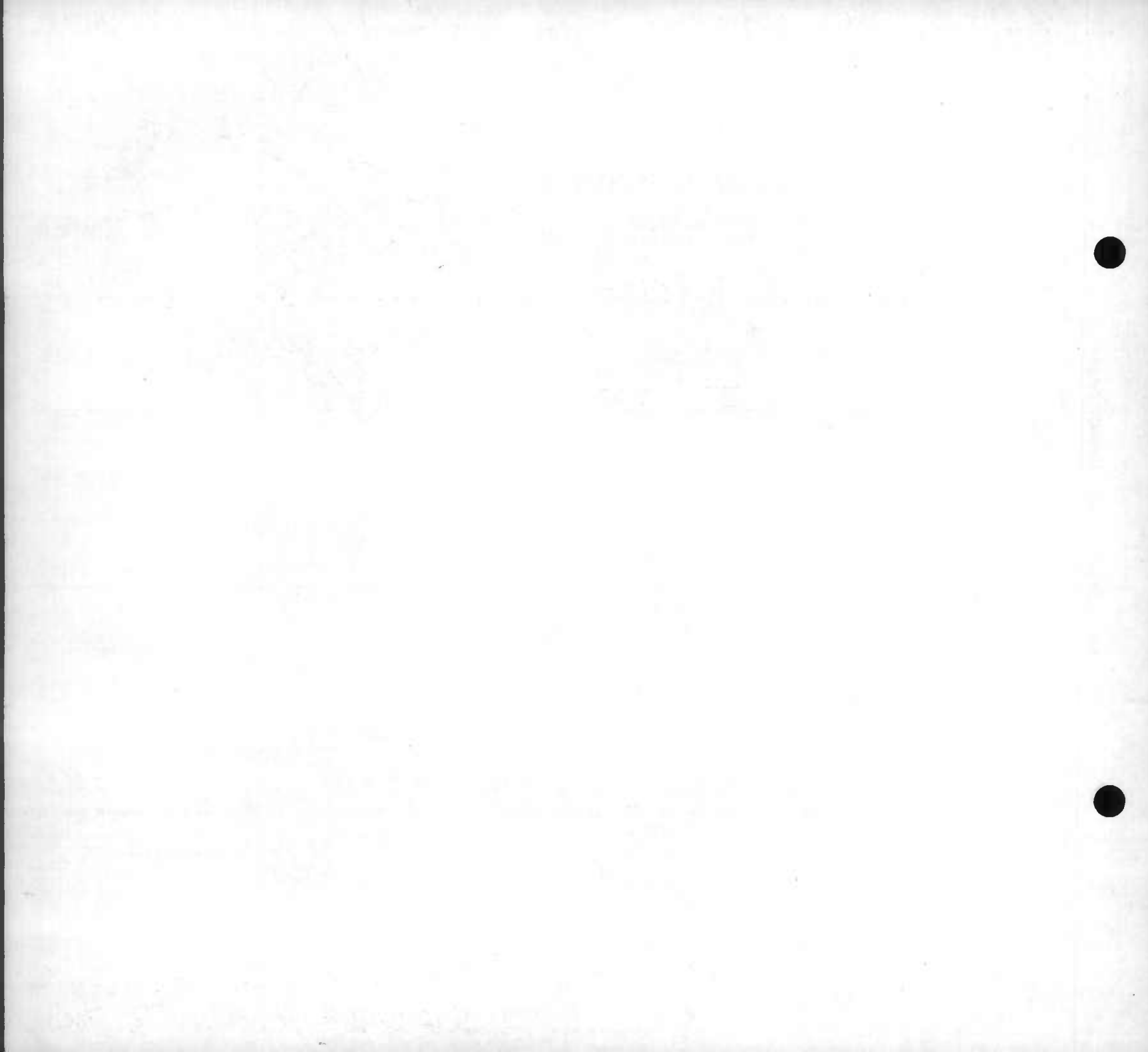
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2678		CERTIFICATE OF DEATH		Registered No. 67 2678	
1. NAME OF DECEASED (Type or Print) <i>James R. O'Keefe</i>				2. DATE AND HOUR OF DEATH <i>3/16/67</i> <i>9:10</i> P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i> <i>48</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY _____					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> <i>26-01</i>					
				D. STREET ADDRESS (If rural, give location) <i>4208 Kolb Ave</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widow</i>		8. DATE OF BIRTH <i>9/23/98</i>		9. AGE (In years lost birthday) <i>68</i>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired CHAUFFEUR</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>BREWERY</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William T O'Keefe</i>				14. MOTHER'S MAIDEN NAME <i>Emma Slattery</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>219-09-1878</i>		17. INFORMANT <i>ELWOOD LYON JR RD 314</i> <i>Sub ROCKEYSVILLE MD</i>		ADDRESS <i>21038</i>	
18. <i>150X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Ca of esophagus</i> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>3/12</i> 19 <i>67</i> to <i>3/16</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>3/16</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Robert M. Byers</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/16/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>ROBERT M. BYERS</i>				23D. ADDRESS <i>MARYLAND GENERAL HOSPITAL</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3/20/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>HOLY REDEEMER</i>		24D. LOCATION (City, town, or county) (State) <i>1400 BELAIR BALTO. MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert M. Byers</i>		25C. FUNERAL DIRECTOR <i>DUPRE BROS INC</i>		ADDRESS <i>7110 BELAIR RD</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2679		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2679	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Charles F. EYLER, JR.</i>		2. DATE AND HOUR OF DEATH <i>3/16/67 16:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>		A. STATE <i>MD.</i> B. COUNTY <i>CARROLL Co.</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Westminster 56-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>RT #4 Box 261-C</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>11/8/26</i>	9. AGE (In years last birthday) <i>40</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Game Warden</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>STATE</i>		11. BIRTHPLACE (State or foreign country) <i>Md USA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles F. Eyer</i>		14. MOTHER'S MAIDEN NAME <i>Alice Wike</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW-II</i>		16. SOCIAL SECURITY NO. <i>220-16-4076</i>		17. INFORMANT <i>Self</i>	
18. <i>163X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Ca of lung</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <i>2/14</i> 19 <i>67</i> to <i>3/16</i> 19 <i>67</i> , that (1) (we) lost saw the deceased alive on <i>3/16</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Robert M. Byers</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/16/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/20/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Leistors Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Westminster RT#4, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>J. E. Rogers, Jr. Westminster, Md.</i>					



B-620

67 2680

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2680

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES G. BURKE

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1967

2:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)35
99 Church Home Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1509 Lancaster Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 18, 1919

9. AGE (In years
lost birthday)

47 48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

Md. Dry Dock

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter S. Burke

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

224-16-0349

17. INFORMANT

ADDRESS

Lillian M Burke-818 S. Bond St.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/20/67

23C. NAME of CEMETERY or CREMATORY

Balto. National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Walters Funeral Home- Balto. Md

ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2681		CERTIFICATE OF DEATH		67 2681	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		HAMMOND EMMA CAROLINE		8XXX 3-14-67 11 40P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
40 ST. AGNES HOSPITAL WILKENS & CATON AVES BALTO. 29, MD		MD. HOWARD Co.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTO. Ellicott City 63-00			
		D. STREET ADDRESS (If rural, give location)			
		44 NORMANDY DR.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	CAUCASIAN	WIDOWED	02-02-85	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN SCHMELTZER		BARBARA NITZEL		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214 54 2189		ST. AGNES RECORDS: WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		Probable cerebral hemorrhage		12-14 hrs.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Bleeding duodenal ulcer			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2/19/67	Bleeding duodenal ulcer				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 11 19 67 to MARCH 14 19 67, that (I) (we) last saw the deceased alive on MARCH 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
R. REVILLA				3-15-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
R. REVILLA		WILKENS & CATON AVES: ST. AGNES HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	3-19-1967	Mt. Zion Baptist		Dronbrook, Essex Co. Va.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
MAR 20 1967	F. C. Higginbotham		F. C. Higginbotham, Ellicott City, Md		

1944-45

CHURCH AND

MEMBERS

THE CHURCH OF
THE LIVING GOD
MEMBERSHIP LIST
1944-45

A.A.

MEMBERS

MEMBERS

1944-45

MEMBERS

MEMBERS

MEMBERS

THE CHURCH OF THE LIVING GOD

MEMBERS

MEMBERSHIP LIST

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1944-45

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THE CHURCH OF THE LIVING GOD

MEMBERSHIP LIST

MEMBERS

MEMBERSHIP LIST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2682	
BIRTH NO. 67 2682		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILDRED A. KOESTER		2. DATE AND HOUR OF DEATH MARCH 16, 1967 5:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSPITAL		A. STATE Md. B. COUNTY 26-44			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE (105 N. Janney St.)			
		D. STREET ADDRESS (If rural, give location) 6115 BELL AIR Rd (GOULD CONVALESCIA)			
5. SEX Female	6. RACE White	7. MARRIED NEVER MARRIED WIDOWED (Specify) Widow	8. DATE OF BIRTH 12/14/1883	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John KELLEY		14. MOTHER'S MAIDEN NAME Mildred Holston			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-36-5725		17. INFORMANT Mrs. Louise Heflin ADDRESS ROBERT ROUBENOFF, N. CHARLES GEN. HOSP.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH 10 Seabright Ave. 21222 INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO ARTERIOSCLEROTIC HEART DIS. (B) DUE TO — (C) DUE TO —			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from MARCH 16, 1967 to MARCH 16, 1967 , that (I) (we) last saw the deceased alive on MARCH 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Roubenoff M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/16/67	
23C. PHYSICIAN'S NAME (Type) ROBERT ROUBENOFF		23D. ADDRESS NORTH CHARLES GEN. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/67		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25A. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave, Dundalk, Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 67 2683		CERTIFICATE OF DEATH		Registered No. 67 2683	
1. NAME OF DECEASED (Type or Print) <i>Rogers, Mary</i>			2. DATE AND HOUR OF DEATH <i>3/17/67</i> <i>935</i> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lincoln Memorial Nursing Home</i> <i>27 N. Carey Street</i> <i>Baltimore, Maryland 21223.</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>13-02</i>		
5. SEX <i>Female</i> 6. RACE <i>Negro</i>			8. DATE OF BIRTH <i>3/28/06</i> 9. AGE (In years last birthday) <i>66</i>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNOWN</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>Greenville N. Carolina</i>		
13. FATHER'S NAME <i>UNKNOWN</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Mrs Odell Myrick 670 W Franklin St</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>			CAUSE OF DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>8/12</i> <i>1966</i> to <i>3/17</i> <i>1967</i> , that (I) (we) last saw the deceased alive on <i>3/17</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John J. ...</i> M.D.			23B. DATE SIGNED <i>3/17/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Harris ...</i> M.D.			23D. ADDRESS <i>5519 Harrison Rd. Balt. Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/22/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cemetery</i>	
24D. LOCATION <i>Baltimore Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead 1206 W North Ave</i>	

3/17/67

3/17/67

321 S. Gay Street
Baltimore, Maryland 21202

3231 Fulton Place
Baltimore

Female Worker

3/28/67

3/28/67

3/28/67

3/28/67

Curry, Thomas

3/17

3/17

3/17

John Doe

John Doe

3231 Fulton Place

3/17/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67-2681	
BIRTH NO. 67 2681		CERTIFICATE OF DEATH				Registered No. 67-2681	
1. NAME OF DECEASED (Type or Print) JOHN STEWART, JR.				2. DATE AND HOUR OF DEATH MARCH 10TH 1967 11.00 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-05 D. STREET ADDRESS (If rural, give location) 408 E. LAFAYETTE AVE 21202			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-11-12	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old Age		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN STEWART, SR.			14. MOTHER'S MAIDEN NAME MARY HENDERSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital chart ADDRESS				
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of lung (B) DUE TO (C) DUE TO II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocardial infarction; Chronic pulmonary disease				19A. DATE OF OPERATION 0			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/3/67 19 to 3/10/67 19 that (I) (we) last saw the deceased alive on 3/10/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John S. Sargent				23B. DATE SIGNED 3/10/67		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) JOHN S. SERGENT				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE OF DEATH MAR 20 1967		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2685		CERTIFICATE OF DEATH		Registered No. 67 2685	
1. NAME OF DECEASED (Type or Print) Besbiel, Michael N.				2. DATE AND HOUR OF DEATH March 15th. 1967 10:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 Saint Agnes Hospital Caton & Wilkens Aves. 2129				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 9.9.C. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Bernie D. STREET ADDRESS (If rural, give location) 52-00 111 Forest dale Ave. Glen Bernie					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 2/2/1897	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Riga, Latvia, Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Besbiel				14. MOTHER'S MAIDEN NAME Margaret Weikel					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I 6/25/17 - 4/17/19				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Margaret Besbiel, Same as #4			
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cardio-Vascular Disease DUE TO 10 yr				INTERVAL BETWEEN ONSET AND DEATH	
				(B) Bronchitis & Asthma DUE TO 15 yr				(C) Diabetes 15 + 20 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1935 to 3/15 1967 , that (I) (we) lost saw the deceased alive on 3/15/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Charles Ball				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/17/67			
23C. PHYSICIAN'S NAME (Type) Charles Ball				23D. ADDRESS M.D. Smithsonian					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Mar. 18, 1967		24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR G. E. E. Taylor		25C. FUNERAL DIRECTOR Harold S. Wade		ADDRESS 550 Wash. Blvd., Laurel, Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2686				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2686	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Robert H LIND			
2. DATE AND HOUR OF DEATH March 18, 1967 1 6 35 A. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MEACHOR CONVALESCENT HOME 90 2327 N CHARLES ST				A. STATE MARYLAND B. COUNTY 7-01			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 2812 E. JEFFERSON ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-20-1896	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN CO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN LIND				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BARBARA WEHNER 2812 E. JEFFERSON ST			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) Coronary Arterio Sclerosis (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 15 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/13 1965 to 3/18 1967 that (I) (we) last saw the deceased alive on 3/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Stanley Z. Felsenberg				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/18/67	
23C. PHYSICIAN'S NAME (Type) STANLEY Z. Felsenberg				23D. ADDRESS M.D. 1129 E. Baltimore St Baltimore 2, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/21/67		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS JOHNNY D. FERGUSON INC 1401 S. CHESTER ST			

2210 E. WILSON ST.
5-17-61
10-10-61

3-2-1961

CONTINENTAL CANO. MACH. CO.

CHICAGO

2011 1110

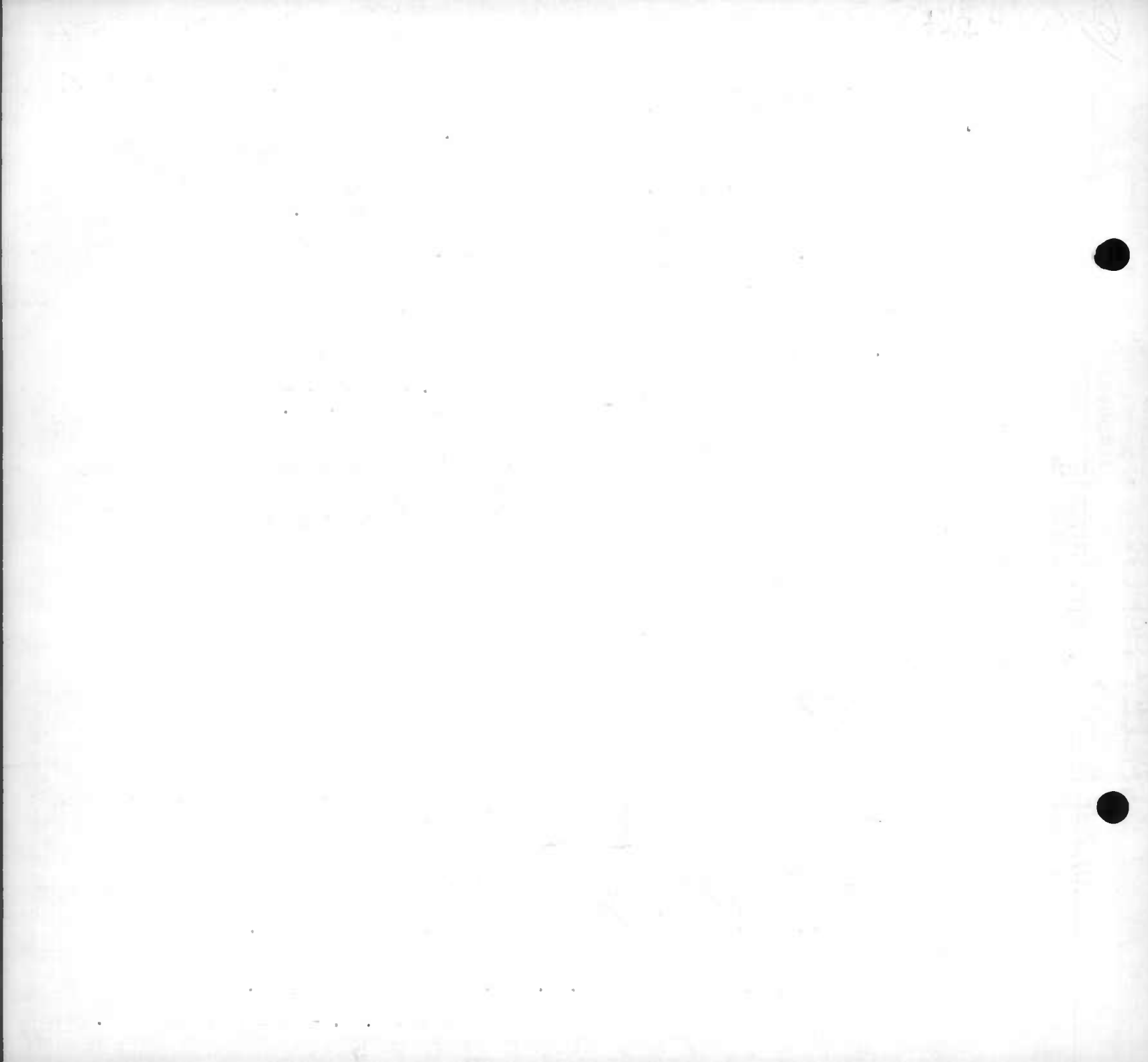
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician has pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 2687					REGISTERED NO. 67 2687					
M.E. CASE NO.					CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) John Watkins					2. DATE AND HOUR OF DEATH March 17, 1967 5:40 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Hood's Nursing Home					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 611 Orpington Rd.					
5. SEX Male	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-11-80	9. AGE (In years lost birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Watkins					14. MOTHER'S MAIDEN NAME Clara Bagley					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-28-7044		17. INFORMANT Mrs. John Watkins			ADDRESS 611 Orpington Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X I Hypertensive Cardiovascular Disease Generalized atherosclerosis					INTERVAL BETWEEN ONSET AND DEATH 10 yrs					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1960 to March 17, 1967, that (I) lost lost saw the deceased alive on March 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE J. Nelson McKay					23B. DATE SIGNED March 29, 1967			23C. PHYSICIAN'S NAME (Type) J. Nelson McKay		
23D. ADDRESS 6014 Edmondson Ave.										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-21-67		24C. NAME of CEMETERY or CREMATORY Fork M. E. Cem.			24D. LOCATION (City, town, or county) (State) Fork, Md.		
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Witake F. D. - 4101 Edmondson Ave.			ADDRESS	



1. NAME OF DECEASED (Type or Print) FRANK P Mc SHANE		2. DATE AND HOUR PRONOUNCED DEAD 3. 17. 67 10⁵⁵ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN Hospital		A. STATE Maryland B. COUNTY Balt. Co	
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00	
		D. STREET ADDRESS (If rural, give location) 5316 West North Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-28-93
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired salesman		10B. KIND OF BUSINESS OR INDUSTRY Dental supply	9. AGE (In years lost birthday) 73 1/4
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - John F. McShane		14. MOTHER'S MAIDEN NAME unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-2636	
		17. INFORMANT Mrs. Helen McShane ADDRESS 5316 W. North Ave. - 21207	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-Vascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) Arteriosclerotic Cardio-Vascular disease (B) Due to (C) 			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner H. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3.18.67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-20-67	
23C. NAME of CEMETERY or CREMATORY New Cathedral Cem.		23D. LOCATION (City, town, or county) (State) Balto., Md.	
24A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		24B. NAME OF REGISTRAR Robert E. Farber, M.D.	
24C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		ADDRESS	

1/14

1/14

1/14

1/14

BIRTH NO.

67 2689

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2689

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BRINLEY R. MADGE, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1967 1:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 802 Winans Way

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

802 Winans Way

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Feb. 18, 1935

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Rev. Brinley R. Madge

14. MOTHER'S MAIDEN NAME

Mary Emily Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Rev. Brinley R. Madge
802 Winans Way - 21229

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-20-67

23C. NAME of CEMETERY or CREMATORY

St. John's Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ellicott City, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

24B. NAME OF REGISTRAR

Robert E. Fairman

24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

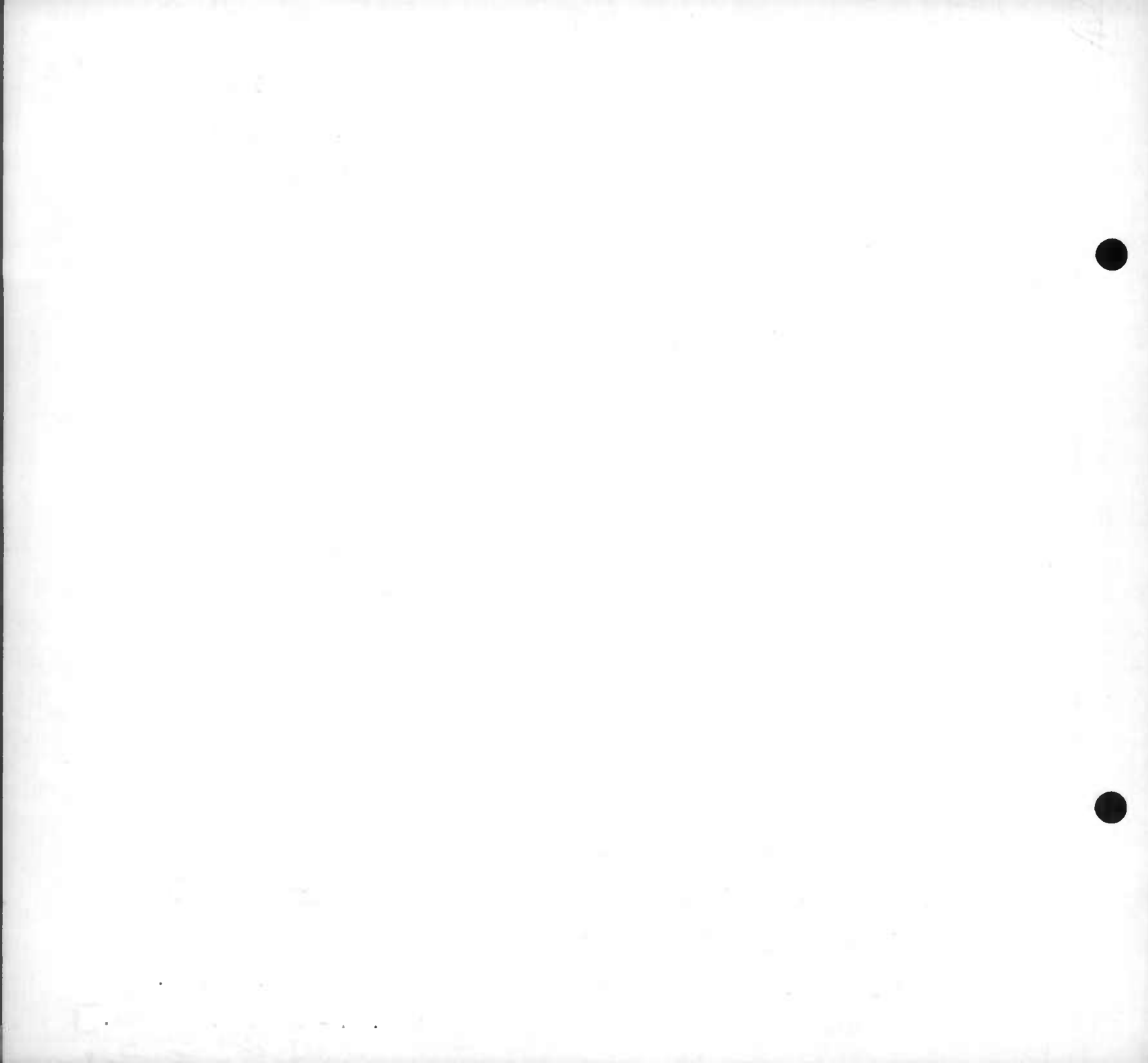
ADDRESS

RECEIVED
FBI

FUNERAL DIRECTOR: IMPORTANT

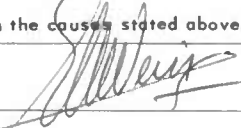
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2690	
BIRTH NO. 260 67 2690		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) John Forest Hager			2. DATE AND HOUR OF DEATH 3/18/67 1 8¹⁵ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FULL NAME OF HOSPITAL OR INSTITUTION University Hosp </div> <div style="width: 45%;"> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-04 D. STREET ADDRESS (If rural, give location) 311 Eds Dale Rd Balt 29.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 4/9/97	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER			10B. KIND OF BUSINESS OR INDUSTRY MANAGER		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Hager		
14. MOTHER'S MAIDEN NAME Charlotte Della Mitchell			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) BROWCHOGENIC CARCINOMA DUE TO (B) C METASTASIS DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 10/64		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/10 19 67 to 3/18 19 67. that (I) (we) last saw the deceased alive on 3/18 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sandia Z. Salan M.D.				23B. DATE SIGNED 3/18/67	
23C. PHYSICIAN'S NAME (Type) SANDIA Z. SALAN M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-67		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Witzke F. D. - 4101 Edmondson Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 2691		67 2691		67 2691	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
SHIMMONS, HAROLD ROBERT			MARCH 16, 1967 9:10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL			A. STATE MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 1027 COOKS LANE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/24/04	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWER		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	11. BIRTHPLACE (State or foreign country) FLORIDA		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Harold R. Shimmons-1027 Cooks Lane		
			ADDRESS ST AGNES RECORDS WILKENS & CATON AVE		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) Bronchopneumonia At Lung</p> <p>(B) Severe Emphysema</p> <p>(C)</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Fibrotic Mediastinal Lymphadenopathy</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 3/15 19 67 to 3/16 19 67 , that (X) (we) last saw the deceased alive on 3/16 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) E. WEISS				23D. ADDRESS ST. AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.	

1. $\log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$ $\frac{1}{n} \log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$

Time (sec)		Time (sec)	
2	2	21.14	21.14
3	3	31.25	31.25

1. $\log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$ $\frac{1}{n} \log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$

1. $\log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$ $\frac{1}{n} \log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$

1. $\log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$ $\frac{1}{n} \log \frac{S}{S_0} = \frac{1}{n} \log \frac{S}{S_0}$

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2692				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2692	
1. NAME OF DECEASED (Type or Print) Nevard Cooper				2. DATE AND HOUR OF DEATH 17 March 1967 3 30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland				A. STATE Maryland B. COUNTY Baltimore					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 17-02					
				D. STREET ADDRESS (If rural, give location) 1126 Shields Ave					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 6 Sept. 1904	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Cooper				14. MOTHER'S MAIDEN NAME Catherine Brown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-07-0215		17. INFORMANT #21224		ADDRESS RECORDS-BCH-4940 EASTERN AVENUE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 153.0+260X				CAUSE OF DEATH (A) Hepatoma DUE TO (B) Cirrhosis DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, Emphysema, Diabetes									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or no) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (we) (this hospital) attended the deceased from 29 December 1966 to 17 March 1967 , that (I) (we) last saw the deceased alive on 16 March 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.									
23A. SIGNATURE Alan J. Barnes M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 17 March 1967			
23C. PHYSICIAN'S NAME (Type) DR. ALAN J. BARNES				23D. ADDRESS 21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/21/67		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY		24D. LOCATION (City, town, or county) (State) A.A. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR R. J. [unclear]		25C. FUNERAL DIRECTOR MORTON DYE		ADDRESS 1701 LAURENS			



1
D. 120

67 2693

BALTIMORE CITY HEALTH DEPARTMENT

67 2693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Dalton Dubose

2. DATE AND HOUR PRONOUNCED DEAD

March 18, 1967

2:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2321 Edmondson Ave.

5. SEX

M.

6. RACE

C.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-18-1926

9. AGE (In years last birthday)

40

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Camden, South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Willie Dubose

14. MOTHER'S MAIDEN NAME

Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary L. Dubose 2321 Edmondson

18.

E982X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Massive internal bleeding DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) stab wound of right side of chest involving the lung. DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

on street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

on street, 2129 Edmondson Ave. 20-02

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

March 18, 67 1:25

21E. INJURY OCCURRED

WHILE AT

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

stabbed

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 18, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3-24-67

23C. NAME OF CEMETERY or CREMATORY

Camden Hill Cem.

23D. LOCATION (City, town, or county)

Camden

(State)

South Carolina

24A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

24B. NAME OF REGISTRAR

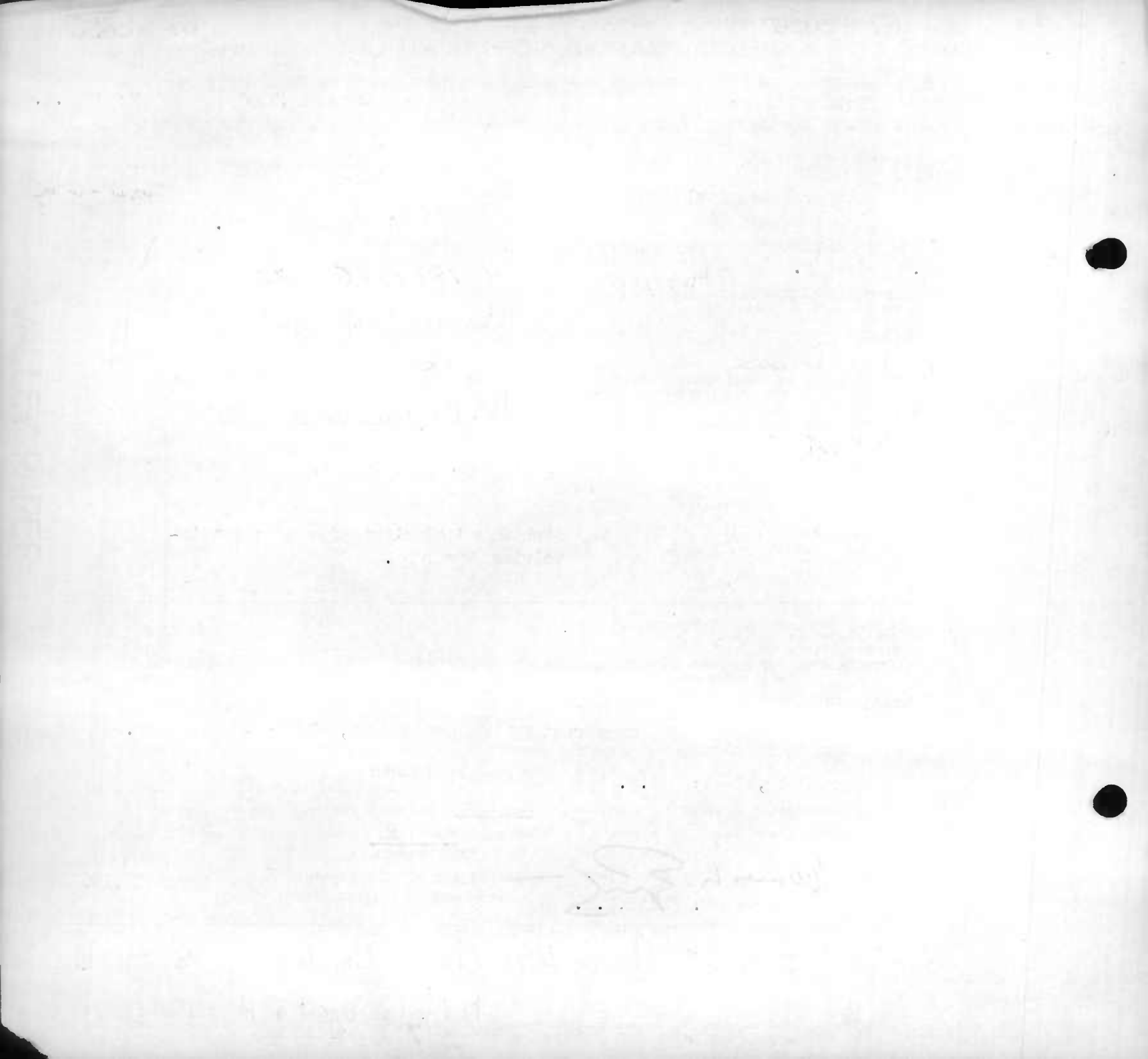
Robert E. Jackson

24C. FUNERAL DIRECTOR

Morton E. Dye

ADDRESS

1701 Laurens St



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEROY O. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1967

11:10 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

00 739 Newington Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

739 Newington Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

4-8-1947

9. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CONTRACTOR

10B. KIND OF BUSINESS OR INDUSTRY

F.O. DAY

11. BIRTHPLACE (State or foreign country)

BALTO., MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES MELVIN SMITH

14. MOTHER'S MAIDEN NAME

MARGARET SPEED

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret Ryan

Railroad Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Acute heroin intoxication

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

739 Newington Avenue

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3-16-67 10:30 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Injected self with heroin

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-19-67

23C. NAME of CEMETERY or CREMATORY

Gough Meth. Ch. Cem.

23D. LOCATION

(City, town, or county)

Cockeysville, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St

WALLEY HALL

1
J-520

67 2695

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2695

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James Jones

2. DATE AND HOUR PRONOUNCED DEAD

3-19-67

4:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

36 Franklin Square Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 16-02
640 N. Carey St

5. SEX

M

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

2-11-1921

9. AGE (in years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Holtite Co.

11. BIRTHPLACE (State or foreign country)

Calvert Co. Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Philmore Jones

14. MOTHER'S MAIDEN NAME

Ella J. Bean

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

214-16-5670

17. INFORMANT

Mr. Sylvester Jones

ADDRESS

204 Katherine St.

18. E 981X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Massive Internal Bleeding

(B) DUE TO

Gunshot wound of Abdomen

(C) DUE TO

involving liver + pancreas

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Tavern

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1200 Edmondson Ave. 16-01

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3-19-67 2:30 A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot in Tavern

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner L. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-19-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-22-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

Arbutus

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 20 1967

Robert E. Spitz

Morton E. Dyett F.H.

1701 Laurens

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/1/01 BY 60322 UCBAW

U.S. AIR FORCE

INVESTIGATION

REPORT

OF THE

INVESTIGATIVE

BRANCH

OF THE

ARMY

AND

NAVY

INVESTIGATIVE

BRANCH

OF THE

ARMY

AND

NAVY

INVESTIGATIVE

BRANCH

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2696	
BIRTH NO. 67 2696				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Gramp, Josephine			2. DATE AND HOUR OF DEATH 3-17-67 1205 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-08 D. STREET ADDRESS (If rural, give location) 3809 Gough Street		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/18/84	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard Keller			14. MOTHER'S/MAIDEN NAME Josephine Snapell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-2954	17. INFORMANT ADDRESS		
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) ASCVD DUE TO (C) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 hr yes. yes.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/15 19 67 to 3/17 19 67 , that (I) (we) last saw the deceased alive on 3/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. H. Brown, III			23B. DATE SIGNED 3/17/67		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) C. H. Brown, III			23D. ADDRESS The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/21/67	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Joseph N. Zannino ADDRESS 263 S. Parkleigh	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>67 2697</u>				
BIRTH NO. <u>67 2697</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Alma Alverta Arnold Tarrant</u>					2. DATE AND HOUR OF DEATH <u>3/16/67</u> <u>4:12 P</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> <u>38</u>					A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>				
					C. CITY OR TOWN (If outside city limits, with RURAL and give township) <u>Baltimore</u> <u>15-47</u>				
D. STREET ADDRESS (If rural, give location) <u>2111 N. Longwood Street</u>									
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>11/4/13</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Greenville, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph Arnold</u>					14. MOTHER'S MAIDEN NAME <u>O/A Blossingano</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>220-12-5050</u>		17. INFORMANT <u>Jamuel Tarrant</u>			ADDRESS <u>-2111 Longwood Street</u>	
18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CA OF COLON</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Wide spread Metastasis</u> <u>Anemia 20 G 1</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>1/31/67</u> 19 <u>67</u> to <u>3/16</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Joseph J. Mowad</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>3/16/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph J. Mowad</u>					23D. ADDRESS <u>University Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/21/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Olive Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Greenville South Carolina</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1967</u>		25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u>		25C. FUNERAL DIRECTOR ADDRESS <u>305 W North Ave.</u>					

1890
The first of the year
The first of the year
The first of the year
The first of the year

The first of the year
The first of the year
The first of the year
The first of the year

The first of the year
The first of the year
The first of the year
The first of the year

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2698				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2698	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DIANA LEE				2. DATE AND HOUR OF DEATH 3/16/67 0145 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY X C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 3-01 D. STREET ADDRESS (If rural, give location) 215 BALLOU COURT 21231			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, NEVER MARRIED	8. DATE OF BIRTH 6-16-64	9. AGE (In years lost birthday) 2	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ROBERT LEE				14. MOTHER'S MAIDEN NAME JOSIE WILLIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert J. Lee 295 BalloU Ct.		ADDRESS	
18. 0534 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain neg. sepsis and ? brain damage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory arrest 30 hrs Marasmus & hyperphagia 20 mos				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Marasmus & hyperphagia			
INTERVAL BETWEEN ONSET AND DEATH 30 hrs				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ?Ventricular syndrome			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/14/67 to 3/16/67 and that (I) (we) lost saw the deceased alive on 3/16/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE J. A. ELLIOTT				23B. DATE SIGNED 3/16/67			
23C. PHYSICIAN'S NAME (Type) J. A. ELLIOTT				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/67		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.		24D. LOCATION (City, town or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. G. MARCH		ADDRESS 928 E. North Ave	



FUNERAL DIRECTOR: IMPORTANT

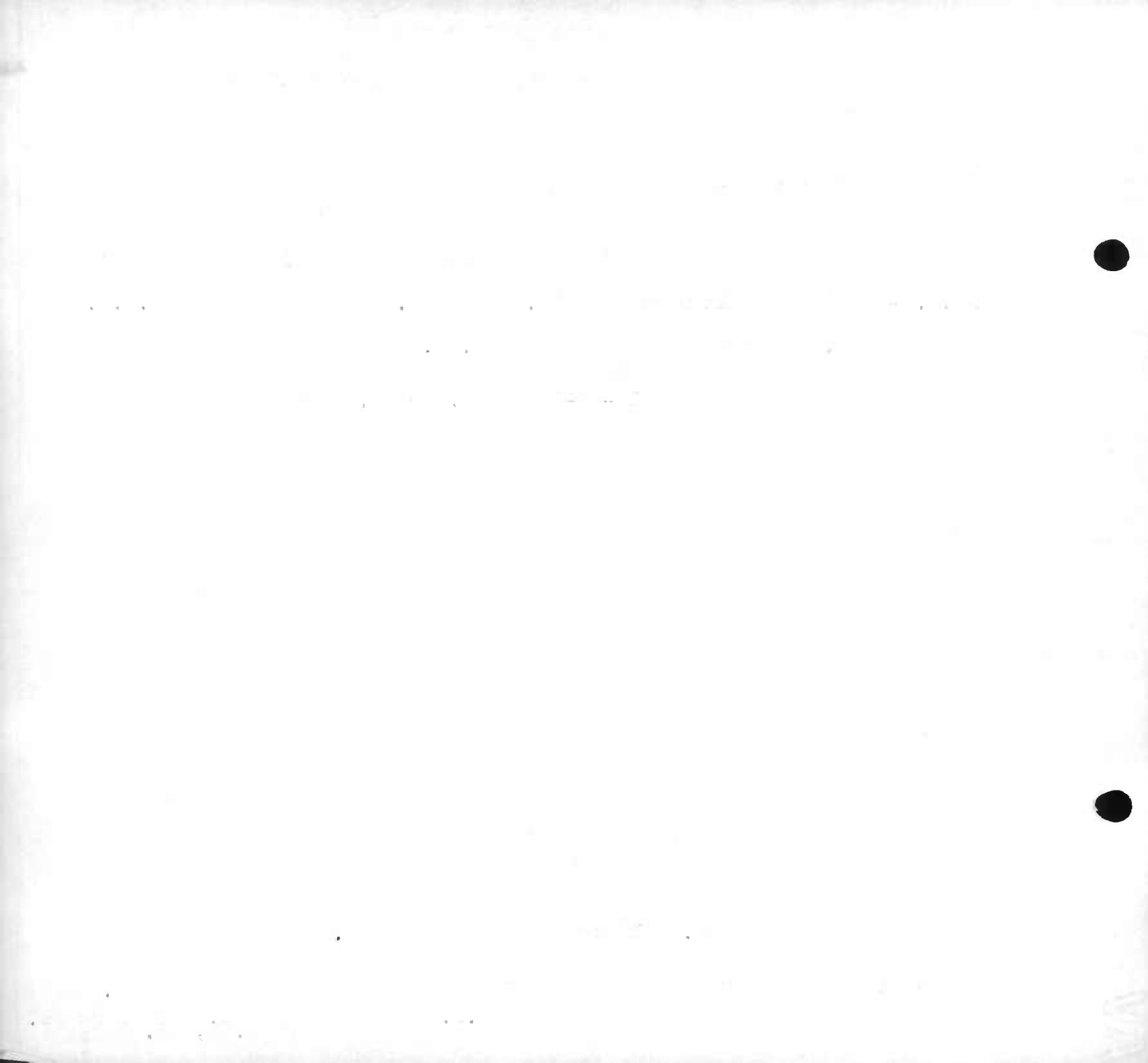
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2699	
BIRTH NO. 67 2699		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JAMES PRESTON SHORT		2. DATE AND HOUR OF DEATH 3-19-67 5 65A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		A. STATE MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 1307			
		D. STREET ADDRESS (If rural, give location) 505 W. UNIVERSITY PKWAY			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 09-13-98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSESSOR-BROKER - INSURANCE		10B. KIND OF BUSINESS OR INDUSTRY (RETIRED)		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME L. S. SHORT		14. MOTHER'S MAIDEN NAME LILLIAN WHITE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-9846		17. INFORMANT ADDRESS MRS. ELIZABETH P. SHORT (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) PULMONARY EMPHYSEMA			
		(B) MYOCARDIAL INFARCTION			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 02-15-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulm. emphysema		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 02-03-67 19 to 03-17-19 67, that (I) (we) last saw the deceased alive on 03-18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 03-19-67	
23C. PHYSICIAN'S NAME (Type) DR ZOLTAN ZARDAY		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/67		24C. NAME of CEMETERY or CREMATORY Parsons	
24D. LOCATION Salisbury, Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR H.W. Jenkins & Sons Co., 4905 York Rd. Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2700				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2700	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William Carroll McKenna				2. DATE AND HOUR OF DEATH March 19, 1967 8 4 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3902 Hadley Square West				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 3902 Hadley Square West			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 10/28/1893	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) V.P. - Retired		10B. KIND OF BUSINESS OR INDUSTRY Emerson Drug Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. McKenna				14. MOTHER'S MAIDEN NAME V. A. Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-0530		17. INFORMANT Mrs. Mary F. McKenna		ADDRESS (Same)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH seconds? ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic heart disease 7+ yrs. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gout							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 14 1961 to Mar 19 1967 , that (I) (we) last saw the deceased alive on Mar 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frederick J. Vollmer M.D.						23B. DATE SIGNED 3-20-67	
23C. PHYSICIAN'S NAME (Type) Frederick J. Vollmer M.D.				23D. ADDRESS 6100 York Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Spivey		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 2701	
CERTIFICATE OF DEATH											
BIRTH NO. 67 2701		M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) MARGARET G. HOFFMAN		2. DATE AND HOUR OF DEATH MARCH 17, 1967 4:45 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD Co.									
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKICOTT CITY 63-00									
D. STREET ADDRESS (If rural, give location) 141 MAC ALPINE RD.											
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-14-98		9. AGE (In years last birthday) 68		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10B. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES GROTHEY				14. MOTHER'S MAIDEN NAME SOPHIE FRYER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-40-4687A		17. INFORMANT KENNETH G. HOFFMAN (ELKICOTT)				ADDRESS SAME			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION ARTERIO-SCLEROTIC CARDIOPATHY DUE TO (B) ASCVD DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH 8 wks. ? years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 01-18-1967 to 03-17-1967, that (I) (we) last saw the deceased alive on 03-17-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE James W. Cartwright, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/17/67			
23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY, JR.				23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-21-67		24C. NAME of CEMETERY or CREMATORY Woodlawn				24D. LOCATION (City, town, or county) (State) Woodlawn Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto., Md.			

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THE FINEST AND MOST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2702				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2702	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lloyd Staley Branch				March 17, 1967 11 ²⁰ A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Gould Convalesarium Belair Road				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 21218 906			
D. STREET ADDRESS (If rural, give location)				1618 E. 31st St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
M	W	Never Married	8/8/1895	71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Runner			Banking		North Carolina		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Henry Branch				Anna May Craig			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes WWI			229-10-2751		Mrs. Eva V. Branch (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Heart Failure (B) DUE TO ASUD (C)		3/13/67 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/16/67 1965 to 3/17/67 1967 that (I) (we) last saw the deceased alive on 3/16/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Walter E. Karfgin						3/18/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Walter E. Karfgin				4331 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/21/1967		Balti-more National		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
		Walter E. Karfgin		H.W. Jenkins & Sons Co. 4905 York Road, Balto. 12, Md.			



M-600

67 2703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2703

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Henry Albert Meyer		Mar. 16, 1967 10:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
US Public Health Service Hospital Wyman Pk. Drive & 31st Street				Florida	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Hialeah	
				D. STREET ADDRESS (If rural, give location)	
				727 E. 32nd Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W	Married	7/19/17	49	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Captain		Seafaring		NJ	USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Henry A. Meyer			Gertrude H. Gould		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes USMC 1933-1964		156-09-5136		Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Days	
(A) DUE TO Pulmonary edema					
(B) DUE TO Carcinoma of the larynx				Years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 27 1966 to Mar. 16 1967, that (I) (we) last saw the deceased alive on Mar. 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelczar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/17/67	
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, S.A. Surgeon (R) M.D.				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Removal		3/17/1967		Roselle, N. J.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 20 1967		Robert E. [unclear]		Wm. F. [unclear] Balto, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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Michael E. Polgar

R-352

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 2704					MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2704				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) K. Donald Redding					2. DATE AND HOUR PRONOUNCED DEAD March 19, 1967 3:40 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodlawn 53-00 D. STREET ADDRESS (If rural, give location) 2014 Kennicot Road				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Oct. 18, 1903	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager			10B. KIND OF BUSINESS OR INDUSTRY W. B. A. L.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Reed Redding				14. MOTHER'S MAIDEN NAME Myra					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. 216-03-2337		17. INFORMANT 14 16 18th South Mrs. Nancy A. Obertier Great Falls, Montana				
18. E 823.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral fractures of tibia and fibula ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Metastatic bronchogenic carcinoma involving the brain									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Falls Rd. South of Harvest Rd.				
21D. TIME OF INJURY (APPROX.) 2 2 67 1:45P		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? Driver of auto into tree 27-14				
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March, 19, 1967									
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/21/1967		23C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery			23D. LOCATION (City, town, or county) (State) Pikesville, Md.		
24A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.			24C. FUNERAL DIRECTOR Wm. F. Fisher & Sons			ADDRESS Baltimore, Md.	

RECEIVED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2705	
BIRTH NO. 67 2705				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Frances M. Sheehan		2. DATE AND HOUR OF DEATH March 20, 1967 9 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2710 Southern Ave.	
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12-29-1895	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Welsh		14. MOTHER'S MAIDEN NAME Regina Hurdle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212105939		17. INFORMANT Robert J. Sheehan	
18. 420111 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion Arteriosclerosis (Generalized)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 3, 1966 to March 20, 1967 , that (I) (we) last saw the deceased alive on MARCH 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew Kurkowski		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/20/67	
23C. PHYSICIAN'S NAME (Type) Andrew Kurkowski		23D. ADDRESS M.D. 2529 Eastern Ave Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3-23-67		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.			

Page 1

Continued

1. The first part of the report

is devoted to a general

discussion of the problem

and the methods used

in the investigation

of the

results of the

investigation

are given in the

appendix

Table

1

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2707				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2707	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) NINA ELIZABETH ROHLFING				2. DATE AND HOUR OF DEATH 3-18-67 10:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 11-02 D. STREET ADDRESS (If rural, give location) 867 PARK AVENUE					
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12-02-01	9. AGE (In years last birthd) 65	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME EASTWOOD James R. Eastwood				14. MOTHER'S MAIDEN NAME Augusta Tunstall					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. ?	17. INFORMANT PATIENT'S CHART			ADDRESS		
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebrovascular accident DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS					
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II									
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that the (this hospital) attended the deceased from 1-10-1967 to 3-18-1967 , that the (we) last saw the deceased alive on 3-18-1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death.									
23A. SIGNATURE Judith Dodrill Gardner M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-18-67			
23C. PHYSICIAN'S NAME (Type) JUDITH DODRILL GARDNER M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 3/18/67		24C. NAME of CEMETERY or CREMATORY Forest Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Norfolk Va.			
25A. DATE REC'D BY HEALTH DEPT. MAY 15 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. ...		ADDRESS ...			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2708		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2708	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) IRVIN SHEATS		
2. DATE AND HOUR OF DEATH 3/18/67 12:45 P.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp. of Baltimore, Inc.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2527 N. Charles St. (Melchor Nursing Home)		
5. SEX M	6. RACE CAU.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated Divorced	8. DATE OF BIRTH 11/4/06	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY GAS STATION		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME EVERETT SHEATS			14. MOTHER'S MAIDEN NAME ANNIE IVENS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-4441		17. INFORMANT ALINDA M. SPARKS ADDRESS 3611 FIELDSTONE RD. RANDALL STON N. MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) DUE TO CARDIAC ARRHYTHMIA (B) DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE (C) GANGRENE OF LEG		
INTERVAL BETWEEN ONSET AND DEATH TERMINAL YEARS			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION SEVERAL - NOV 66 - FEB 67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE OF LEG		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 11/5 19 66 to 3/18 19 67, that (B) (we) last saw the deceased alive on 3/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Brett Lazar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/18/67	
23C. PHYSICIAN'S NAME (Type) J. BRETT LAZAR		23D. ADDRESS Sinai Hosp. of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. Tichner & Sons Baltimore, Md.			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

SNAIR

2. DATE AND HOUR PRONOUNCED DEAD

March 14, 1967

10:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
ADDRESS OR LOCATION)

00 1807 N. Calvert Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1807 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10/1/1908

9. AGE (In years
lost birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Shipfitter

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John

Snair

14. MOTHER'S MAIDEN NAME

Mary

E.

Keane

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-07-5441

17. INFORMANT

ADDRESS

Mr. John Snair 114 S. Tremont Rd. 29

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/14/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-17-67

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Wm. J. Lickner + Sons, Inc.

ADDRESS

North Howard St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

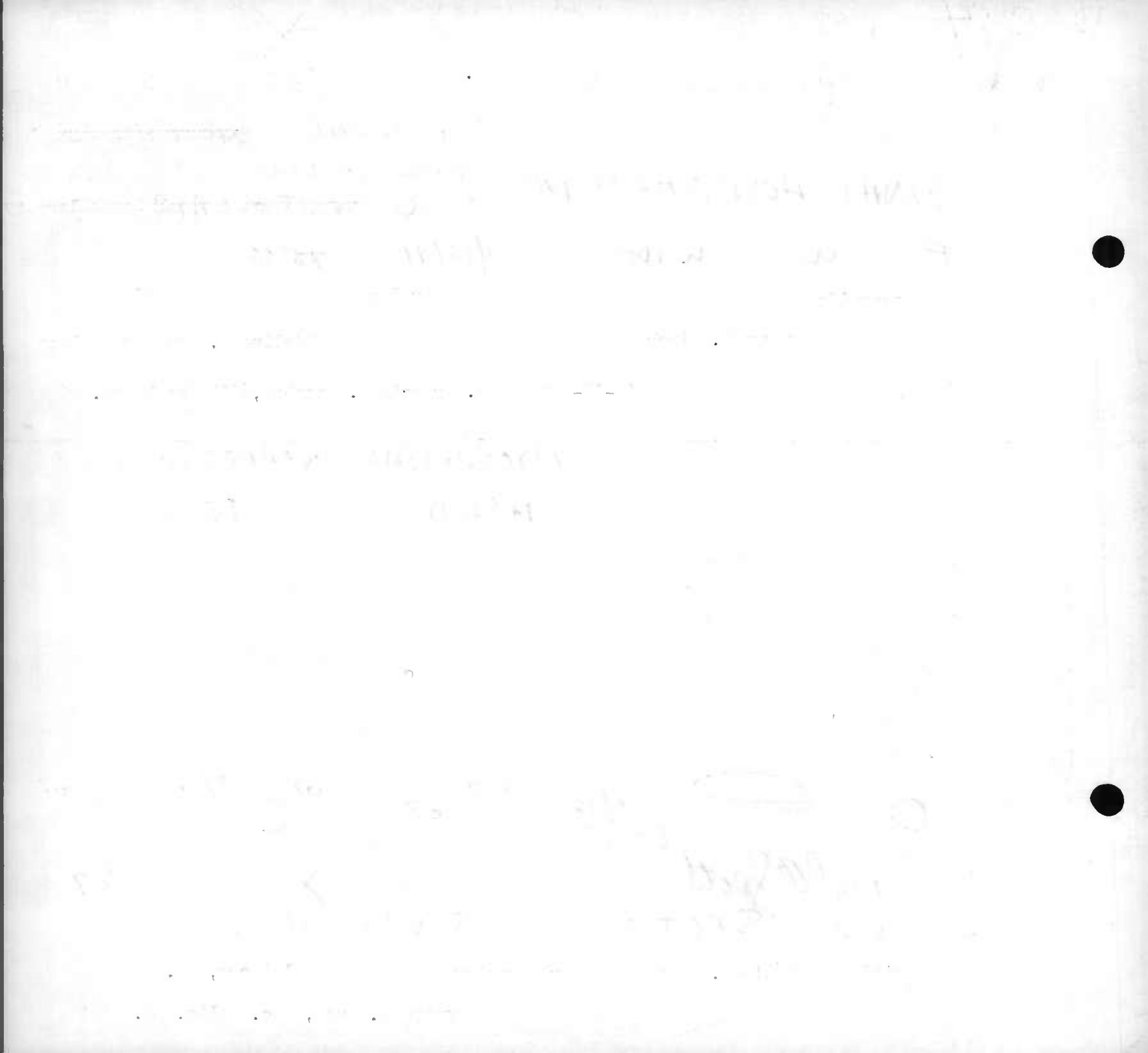
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2710	
BIRTH NO. 67 2710				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) FERGUSON, Reid Edwards	
2. DATE AND HOUR OF DEATH March 15, 1967 9:40 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3612 Rosedale Road		5. SEX Male		6. RACE White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 7/6/91		9. AGE (In years lost birthday) 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - postal clerk		10B. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eli Ferguson		14. MOTHER'S MAIDEN NAME Mary Agnes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/17/17 to 5/17/19		16. SOCIAL SECURITY NO. PN622-07-0691		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md. 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				1-Chronic obstructive airway disease ? 8 years 2-Cor pulmonale ? 8 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from March 14, 1967 to March 15, 1967, that (X) (we) last saw the deceased alive on March 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry N. Rosenbaum M.D.				23B. DATE SIGNED March 16, 1967	
23C. PHYSICIAN'S NAME (Type) BARRY ROSENBAUM				23D. ADDRESS VA Hospital 3900 Loch Raven Blvd., Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 3/17/1967		24C. NAME of CEMETERY or CREMATORY Lancaster, South Carolina	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. A. Zickert Sons Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

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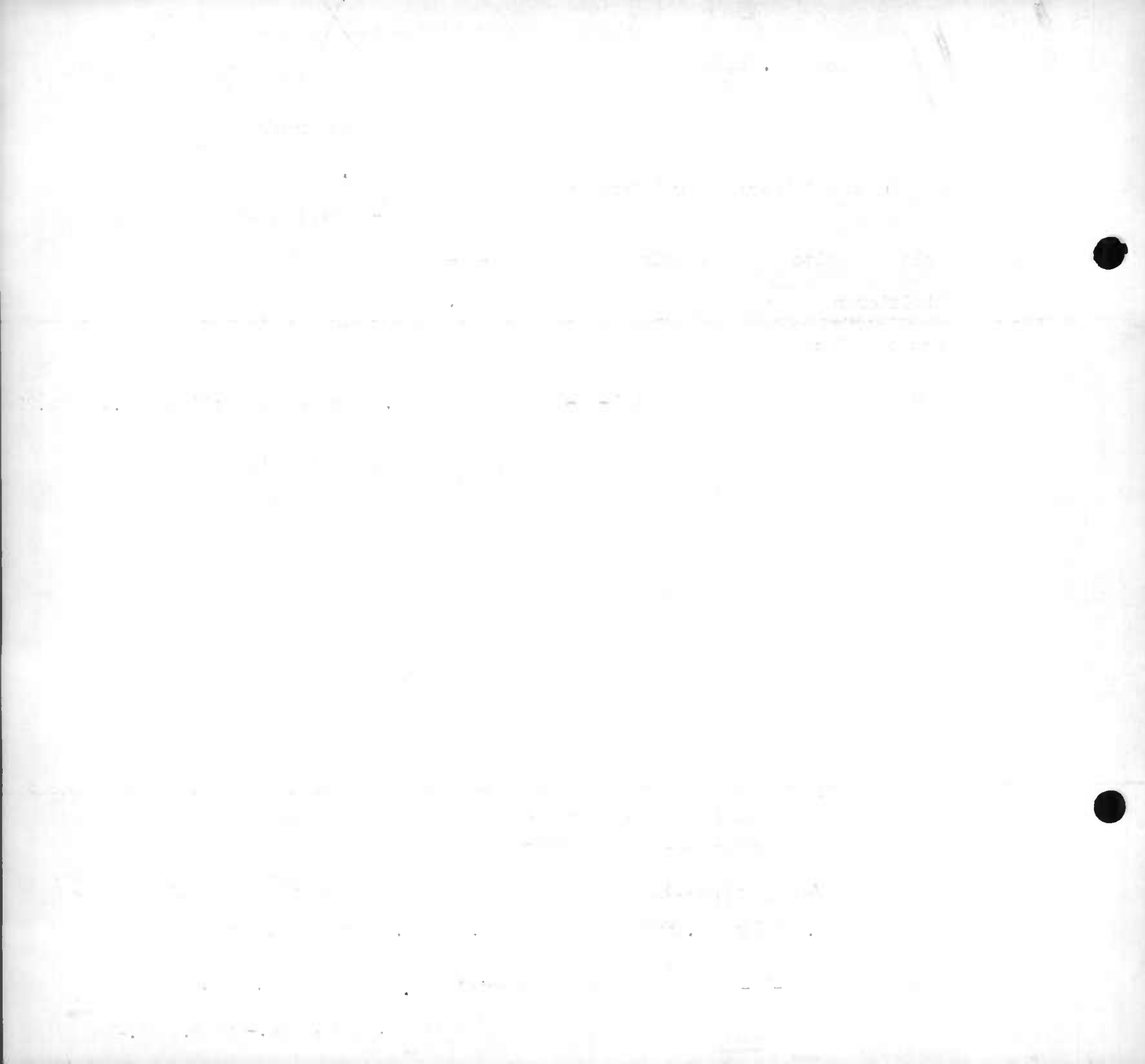
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2711		CERTIFICATE OF DEATH		67 2711	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DARNELL, LOUISE W.		2. DATE AND HOUR OF DEATH 3/18/67 15:15A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALT		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-03 D. STREET ADDRESS (If rural, give location) 3950 South Clareway			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 1/15/91	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George P. Streb		14. MOTHER'S MAIDEN NAME Adeline F. Von Spreckelson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-8756		17. INFORMANT ADDRESS Mr. Francis C. Renshaw, 6217 Brook Ave. #6	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION 1 DAY DUE TO (B) ASAD DUE TO 10 yrs (C)		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/17 19 67 to 3/18 19 67 , that (I) (we) last saw the deceased alive on 3/18 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel A. Spott		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/18/67	
23C. PHYSICIAN'S NAME (Type) D.A. SPOTT		23D. ADDRESS SINAI HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR Robert E. Staley		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto, Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 2712					Registered No. 67 2712				
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Leon A. Black					2. DATE AND HOUR OF DEATH 3-17-67 6:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital					A. STATE B. COUNTY Maryland Anne Arundel Co.				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena Md. 52-00				
					D. STREET ADDRESS (If rural, give location) Box 407 -B West Shore				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Male	White	Married	8-14-04	62					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Upholsterer					Md.			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Jacob Black					Mary ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			212-07-3619		Donald L. Black - 8020 Wallace Rd., Balto. 22				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO Lymphosarcoma				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (1) (this hospital) attended the deceased from 3-2 19 67 to 3-17 19 67 , that (1) (we) last saw the deceased alive on 3-17 19 67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
William J. Marek M.D.					3-17-67				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Dr. William J. Marek					S. Balto. General Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
burial			3-21-67		Meadowridge Memorial Cem.		Howard Co., Md. (Elkridge)		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
MAR 20 1967			Robert E. Galka			Leonard J. Ruck, Inc. - Balto., Md. - 14			



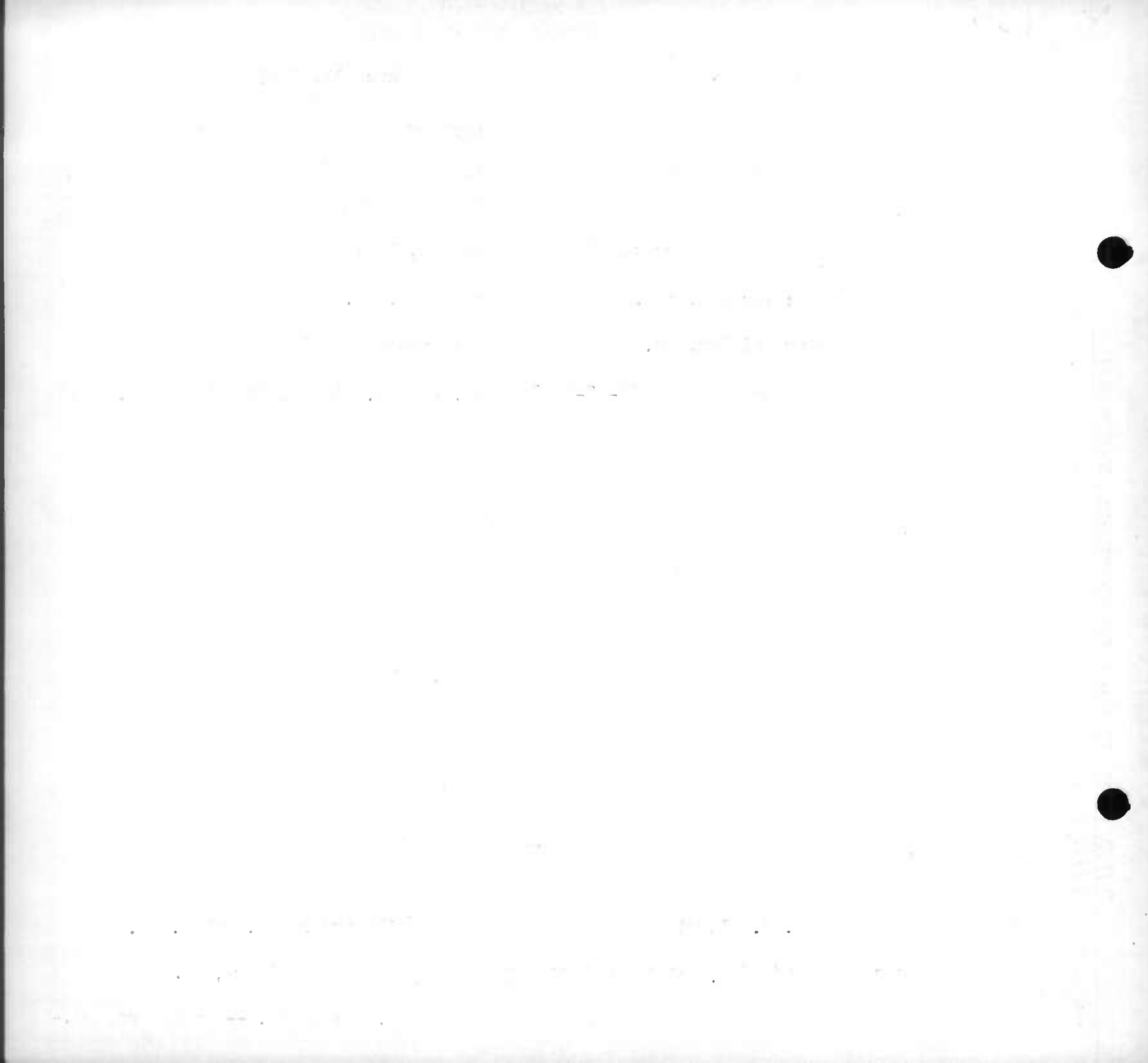
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 2713		67 2713	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MARIE ROSE JONES			March 17, 1967. 6 ¹⁰ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 1655 E. Cold Spring Lane			A. STATE Md. B. COUNTY		
5. SEX Female			6. RACE White		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH Sept. 12, 1902		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Frank LaBarrer			14. MOTHER'S MAIDEN NAME Mattie Foxwell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-10-8072		
17. INFORMANT Mr. Robert H. Jones			ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Ca of Cervix			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 15 1966 to March 17 1967, that (I) (we) last saw the deceased alive on 3/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Rubin			23B. DATE SIGNED 3/19/67		
23C. PHYSICIAN'S NAME (Type) Samuel Rubin			23D. ADDRESS 203 Patapsco Ave Baltimore Md. 21225		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/67.		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME OF CEMETERY or CREMATORY		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2714				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2714	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				GEORGE H. MILLER		March 17, 1967 11:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 3209 Mary Avenue				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 21214 27-44			
				D. STREET ADDRESS (If rural, give location)			
				3209 Mary Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
male	white	married	April 5, 1907	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
exterminator: insects, etc.			Baltimore, Md.		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Howard Miller, Sr.				Margarett Viewig			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes WW 1 Navy			214-03-5222		Mrs. Jean E. Miller, 3209 Mary Ave. #14		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				2 1/2 months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from March 1963 to March 17 1967, that (I) (we) lost saw the deceased alive on March 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
E. J. Alessi						3/18/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				6217 Harford Rd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/21/67		Baltimore National Cemetery		Baltimore, Md.	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 20 1967		Robert E. Salyer		Leonard J. Ruck, Inc.		-- Baltimore, Md.-14	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 2715					Registered No. 67 2715				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED BRISH, RUSSELL GOODWIN					17 MARCH 67 4:20 AM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP.					A. STATE MD B. COUNTY BALTIMORE				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21213				
44					D. STREET ADDRESS (If rural, give location) 3600 CROSSLAND AVE.				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 04-02-87	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from BETHLEHEM STEEL			10B. KIND OF BUSINESS OR INDUSTRY MD		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME TYSON BRISH			14. MOTHER'S MAIDEN NAME FLORENCE Banta						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-07-0303A		17. INFORMANT Mrs. Catherine M. Brish		ADDRESS (Same)		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE					2 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. G.I. bleeding									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 15 MARCH 19 67 to 17 MARCH 19 67 , that (I) (we) last saw the deceased alive on 17 MARCH 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Sidney E. Kirkdey					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 17 MARCH 67		
23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKDEY,					23D. ADDRESS THE UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/67.		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214			

BRISH EUGENE KIMBORN

17 MARCH 67

UNION MEMORIAL MUSE

BATIMORE

W M MARRIED

04-0-47 79

RECEIVED FROM BETHANN STEER

MD

~~RECEIVED FROM~~
TYSON BRISH

FLORENCE

U.S.A.

1967

CORRECTION MEMORANDUM

1967

61.10.1967

No

17 MARCH 67

12 MARCH 67

67

17 MARCH 67

William E. Kimbryn

WILLIAM E. KIMBRYN

✓

17 MARCH 67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2716BIRTH NO. 67 2716

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES E. JORDAN

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1967

2:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)44
99 Union Memorial Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1208 Woodbourne Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

August 23, 1890.

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Plumber

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY? USA

13. FATHER'S NAME

Charles E. Jordan

14. MOTHER'S MAIDEN NAME

?

Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Joseph Jordan, 3305 Gibbons Ave. Balto. #14

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/20/67.

23C. NAME of CEMETERY or CREMATORY

Dulaney Valley Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 20 1967

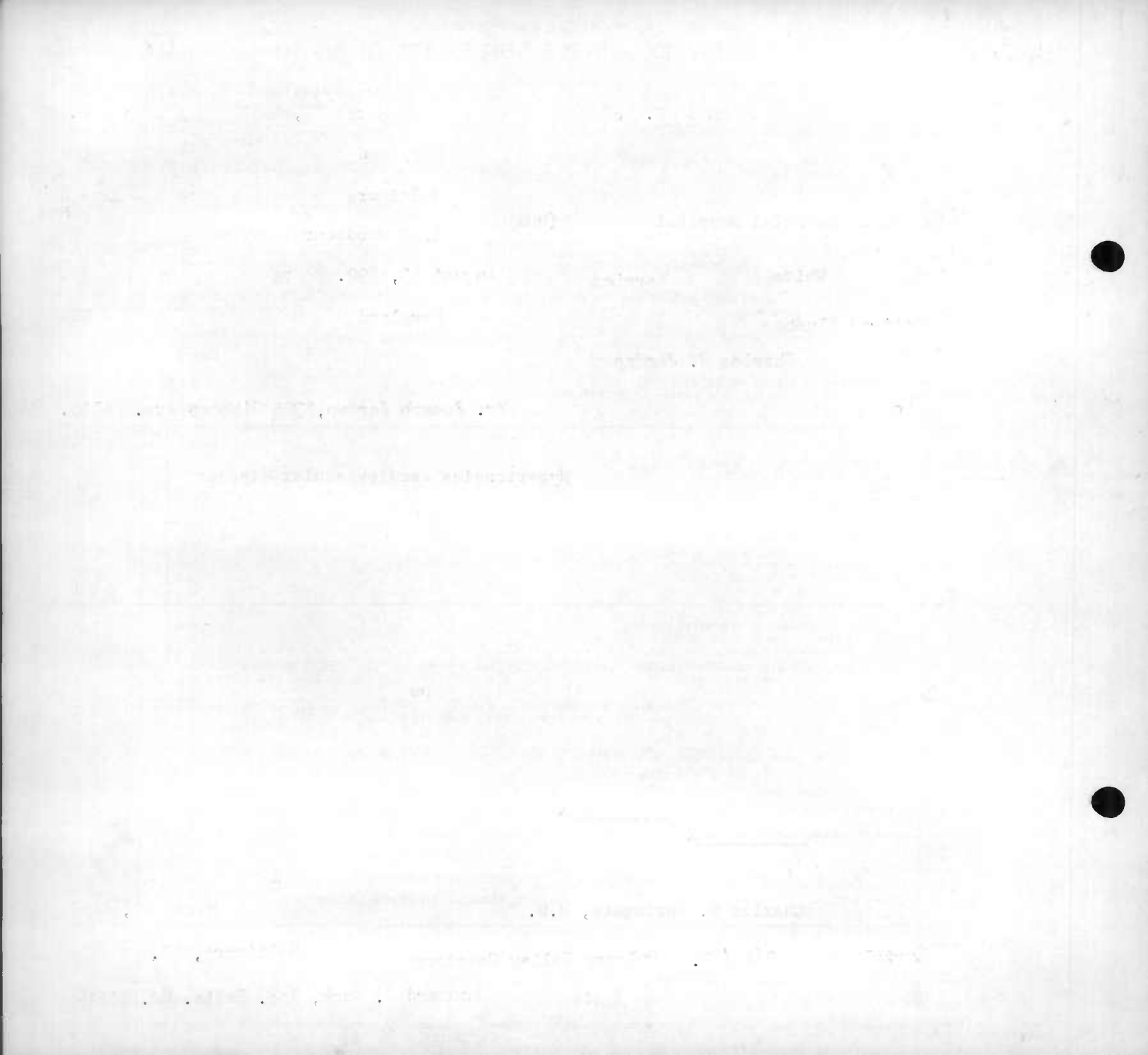
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2717	
BIRTH NO. 67 2717		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GILLINGHAM LEE HARWOOD		2. DATE AND HOUR OF DEATH MARCH 16TH 1967 4:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3906 OLD YORK BALTIMORE 9-01 D. STREET ADDRESS (If rural, give location) 3906 OLD YORK ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-19 1883	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Paint)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES GILLINGHAM			12. CITIZEN OF WHAT COUNTRY? AMERICAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 579-07-3493		17. INFORMANT Mrs. Marie L. Gillingham
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. UREMIA ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-14 1967 to 3-16 1967 , that (I) (we) last saw the deceased alive on 3-16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fridtjofur Bjornsson				23B. DATE SIGNED 3-16 '67	
23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON				23D. ADDRESS THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR John A. Moran, Inc.		25C. FUNERAL DIRECTOR John A. Moran, Inc.			
25D. ADDRESS 3000 E. Balto. St.					

MEMORIAL HOSPITAL

MARY WHITE

JAMES GILLINGHAM

ALICE HARDY

MARYLAND

11-19 1883 83

3906 OLD YORK ROAD
BALTIMORE

MARYLAND

CONGESTIVE HEART FAILURE

WRE MIA

ARTERIO-SCLEROTIC DISEASE
VASCULAR

No

FRIDTJOF BJORNSON

UNION MEMORIAL HOSPITAL

3-12

3-14

10

10

10

10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 67 2718					CERTIFICATE OF DEATH					Registered No. 67 2718						
1. NAME OF DECEASED (Type or Print) CAMPOULI MR ALEXANDER					2. DATE AND HOUR OF DEATH 3-17-67 18:40 A M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSP.					A. STATE MD					B. COUNTY						
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					6-01						
					D. STREET ADDRESS (If rural, give location) 155 N. CURLEY ST. (24)											
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6.2.93		9. AGE (In years last birthday) 73		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caulker					10B. KIND OF BUSINESS OR INDUSTRY Baltimore City					11. BIRTHPLACE (State or foreign country) ITALY					12. CITIZEN OF WHAT COUNTRY? AMER.	
13. FATHER'S NAME CAMPOULI, Alexander					14. MOTHER'S MAIDEN NAME unknown											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI					16. SOCIAL SECURITY NO. 220-01-4498A					17. INFORMANT CHURCH HOME & HOSP					ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 331X I Cerebral Hemorrhage 3 days					(A) DUE TO					(B) DUE TO					(C) Atherosclerosis, gen. Yes.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 3.15.1967 to 3.17.1967, that (I) (we) last saw the deceased alive on 3.17.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE J. C. MARIANO					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 3-17-67						
23C. PHYSICIAN'S NAME (Type) J. C. MARIANO					M.D.					23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, MD.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 3/22/1967					24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR MAR 20 1967					25C. FUNERAL DIRECTOR John A. Moran Inc.					ADDRESS 3000 E. Baltimore St.	

7/11

Atkinson, J. W.

To Mr. J. W. Atkinson
1000

Atkinson, J. W.
1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 2719					CERTIFICATE OF DEATH					Registered No. 67 2719				
1. NAME OF DECEASED (Type or Print) Renie Elizabeth Schildt										2. DATE AND HOUR OF DEATH 3-16-67 12:15 PM 12:15 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital Baltimore, Md										A. STATE Md B. COUNTY Baltimore Co.				
(If not in hospital or institution, give street address or location)										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 53-00				
										D. STREET ADDRESS (If rural, give location) 20 Clarendon Av.				
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH Jan 8, 1919		9. AGE (In years last birthday) 48 yrs		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse					10B. KIND OF BUSINESS OR INDUSTRY Rosewood					11. BIRTHPLACE (State or foreign country) Waxonsboro, Penn			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert C. Ingels										14. MOTHER'S MAIDEN NAME Annie E. Dowling				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 215-22-4980		17. INFORMANT Corroll Schildt			ADDRESS same				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis (A) DUE TO										INTERVAL BETWEEN ONSET AND DEATH —				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD (B) DUE TO (C)														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 14 July 1951 to 16 March 1967 , that (I) (we) last saw the deceased alive on 16 March 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Charles H. Williams										23B. DATE SIGNED 3-16-67				
23C. PHYSICIAN'S NAME (Type) Charles H. Williams										23D. ADDRESS Pikesville 8, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE March 20, 1967					24C. NAME OF CEMETERY or CREMATORY Ridge Cemetery				
24D. LOCATION (City, town, or county)					24E. LOCATION (City, town, or county)					24F. LOCATION (City, town, or county)				
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967					25B. NAME OF REGISTRAR Frank A. Newell					25C. FUNERAL DIRECTOR Frank A. Newell				



1
5-420

67 2720

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2720

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DONALD E. SLUSS

2. DATE AND HOUR PRONOUNCED DEAD

3-15-67

12:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)40
99 ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5011 E. Hoffman Street 21205

26-34

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

11/22/1932

9. AGE (in years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

unknown

10B. KIND OF BUSINESS OR INDUSTRY

unknown

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Sluss

14. MOTHER'S MAIDEN NAME

Loe Poindexter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Korean War

16. SOCIAL
SECURITY NO.

225-38-9512

17. INFORMANT

Parents, above

ADDRESS

18.

E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Highway

21C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR? Washington Blv'd - 306' South
of New Lansdowne Road 53-0021D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 15 '67 12:03 AM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-15-67

23A. BURIAL CREMATION,
REMOVAL (Specify)Transit
Burial

23B. DATE

3/18/67

23C. NAME of CEMETERY or CREMATORY

Maple Hill Cemetery

23D. LOCATION

(City, town, or county)

Bluefield, Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

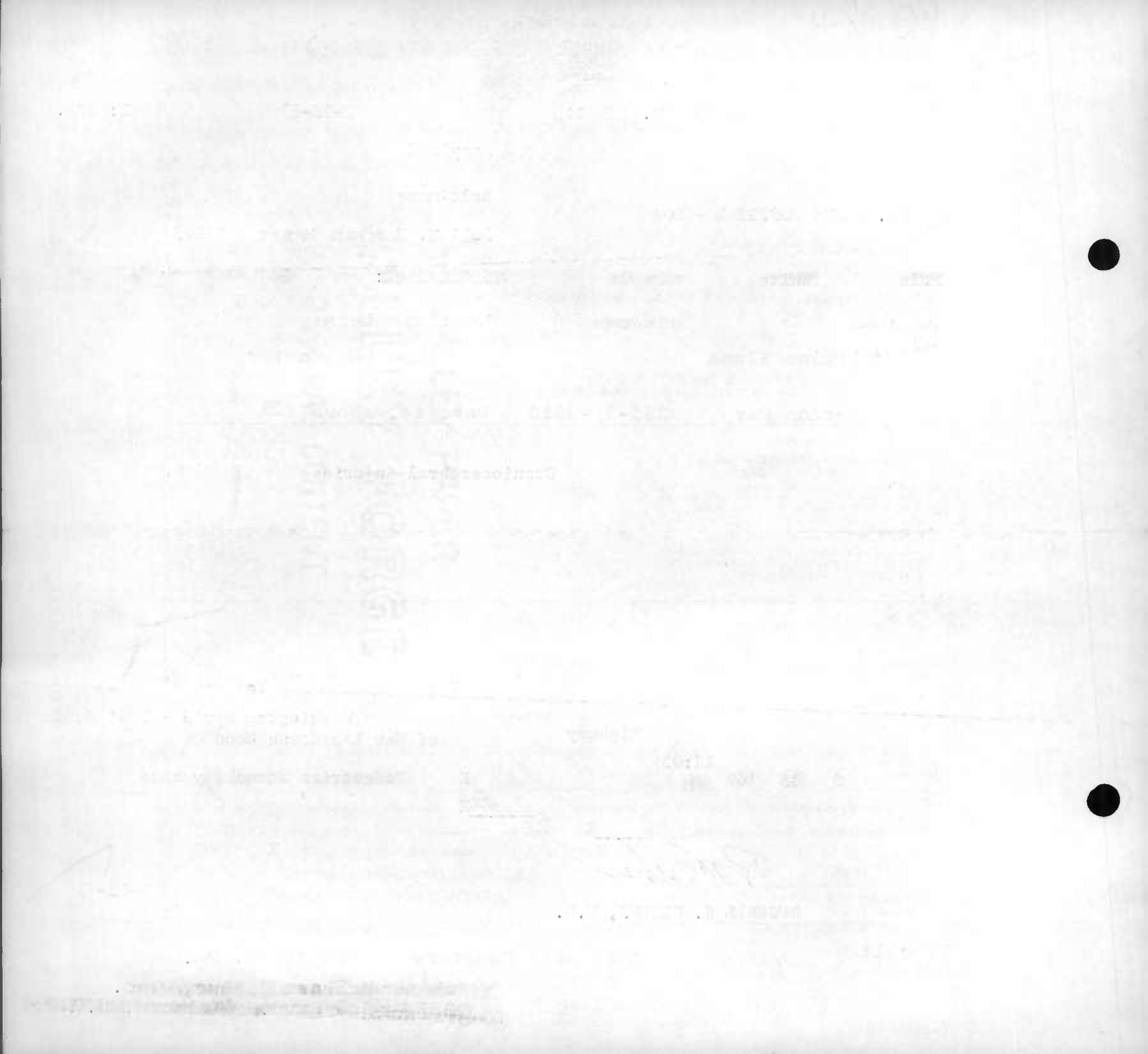
ADDRESS

MAR 20 1967

Robert E. Fisher, M.D.

Schimunek Funeral Home, Inc.

3331 Brehms Lane, Baltimore, Md. 21213



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2721	
BIRTH NO. 67 2721		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (also known as, Katherine L. Upton)		2. DATE AND HOUR OF DEATH MARCH 16 1967 13:45 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOUR HOSPITAL 34		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 8-01 D. STREET ADDRESS (If rural, give location) 3115 CLIFTMONT AVENUE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-29-93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Blums Dept. Store	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES METZLER			14. MOTHER'S MAIDEN NAME BELHOFF, Elizabeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-22-1108A	17. INFORMANT Charles H. Upton, husband, above		
18. 433.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO ATRIAL FIBRILLATION + PULMONARY EDEMA		4 DAYS	
ANTECEDENT CAUSES		(B) DUE TO CONGESTIVE HEART FAILURE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 14 1967 to MARCH 16 1967, that (I) (we) last saw the deceased alive on MARCH 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose T. Villa Jr.				23B. DATE SIGNED 3/16/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/67		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967			
25B. NAME OF REGISTRAR Robert E. Schimunek		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK

1-1-56 X

2-1-56

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2722				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2722	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN N. MILLER				2. DATE AND HOUR OF DEATH March 15, 1967 9:20 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 99 Hopkins Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., 21205 B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 7-05 D. STREET ADDRESS (If rural, give location) 815 N. Chapel Street			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10/24/1893	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman			10B. KIND OF BUSINESS OR INDUSTRY Gilford Folding Box Co. Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John F. Miller			14. MOTHER'S MAIDEN NAME Katherine Frantz				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-07-2381		17. INFORMANT ADDRESS Irene Miller, wife, above		
18. 442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) cardio-renal-vascular disease				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 weeks.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. general anoxia, chr. nephritis				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 23 19 67 to March 15 19 67 , that (I) (we) last saw the deceased alive on March 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. C. Dobihal M.D.				23B. DATE SIGNED 3/17/67			
23C. PHYSICIAN'S NAME (Type) Dr. Louis C. Dobihal				23D. ADDRESS 447 N. Kenwood Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/67		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1967		25B. NAME OF REGISTRAR Robert E. Schimunek		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 67 2723					CERTIFICATE OF DEATH					Registered No. 67 2723									
1. NAME OF DECEASED (Type or Print) <i>Mellema Martha F.</i>										2. DATE AND HOUR OF DEATH <i>3/16/67 10 P.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hosp.</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>#2</i> D. STREET ADDRESS (If rural, give location) <i>3113 Greenmount Ave</i>									
5. SEX <i>F</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>11-11-00</i>		9. AGE (In years last birthday) <i>66</i>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Operator</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Shoe factory</i>					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>John T. Bates</i>										14. MOTHER'S MAIDEN NAME <i>Mundell</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>215-18-5905</i>					17. INFORMANT ADDRESS <i>Ernest R. Mellema Jr. 1807 Desota Rd. 21230</i>									
18. I <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Cerebrovascular accident.</i> (B) <i>anterior stroke</i> (C) <i>cardiovascular disease.</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 WEEKS</i>										19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>MARCH 4 1967</i> to <i>MARCH 16 1967</i> , that (I) (we) last saw the deceased alive on <i>MARCH 16 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>J.T. Villa Jr. M.D.</i>										23B. DATE SIGNED <i>3/16/67</i>									
23C. PHYSICIAN'S NAME (Type) <i>J.T. Villa Jr.</i>										23D. ADDRESS <i>M.D.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>3/20/67</i>					24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 20 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. ...</i>					25C. FUNERAL DIRECTOR <i>Walter ...</i>					25D. ADDRESS <i>Home ...</i>				

1926

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White

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W-452 67 2724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2724

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		THORNTON WILLIAMS		2. DATE AND HOUR PRONOUNCED DEAD March 19, 1967 5:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital				A. STATE Maryland B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
				Baltimore 8-05	
D. STREET ADDRESS (If rural, give location)				1830 N. Dallas Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Negro	SINGLE	10/31/42	24	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER				Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JESSE WILLIAMS			THORNTON DAVIS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				THORNTON WILLIAMS 1830 N. DALLAS ST.	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stab wound of Chest (A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO					
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Bar		2443 E. Preston Street 8-03	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Stabbed during altercation.	
3 19 '67 P					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Petty		3/20/67	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
BURIAL		3/23/67		MT. CALVARY	
23D. LOCATION (City, town, or county) (State)		23E. DATE REC'D BY HEALTH DEPT.		23F. NAME OF REGISTRAR	
A.A. County, Md.		MAR 21 1967		Joseph J. Rock	
23G. FUNERAL DIRECTOR ADDRESS		23H. NAME OF REGISTRAR		23I. DATE OF DEATH	
1304 N. Central St.					

2. nplc

LABORER

BESSIE WILLIAMS

No.

10/31/12

DATE WED.

THURSDAY 10/31/12

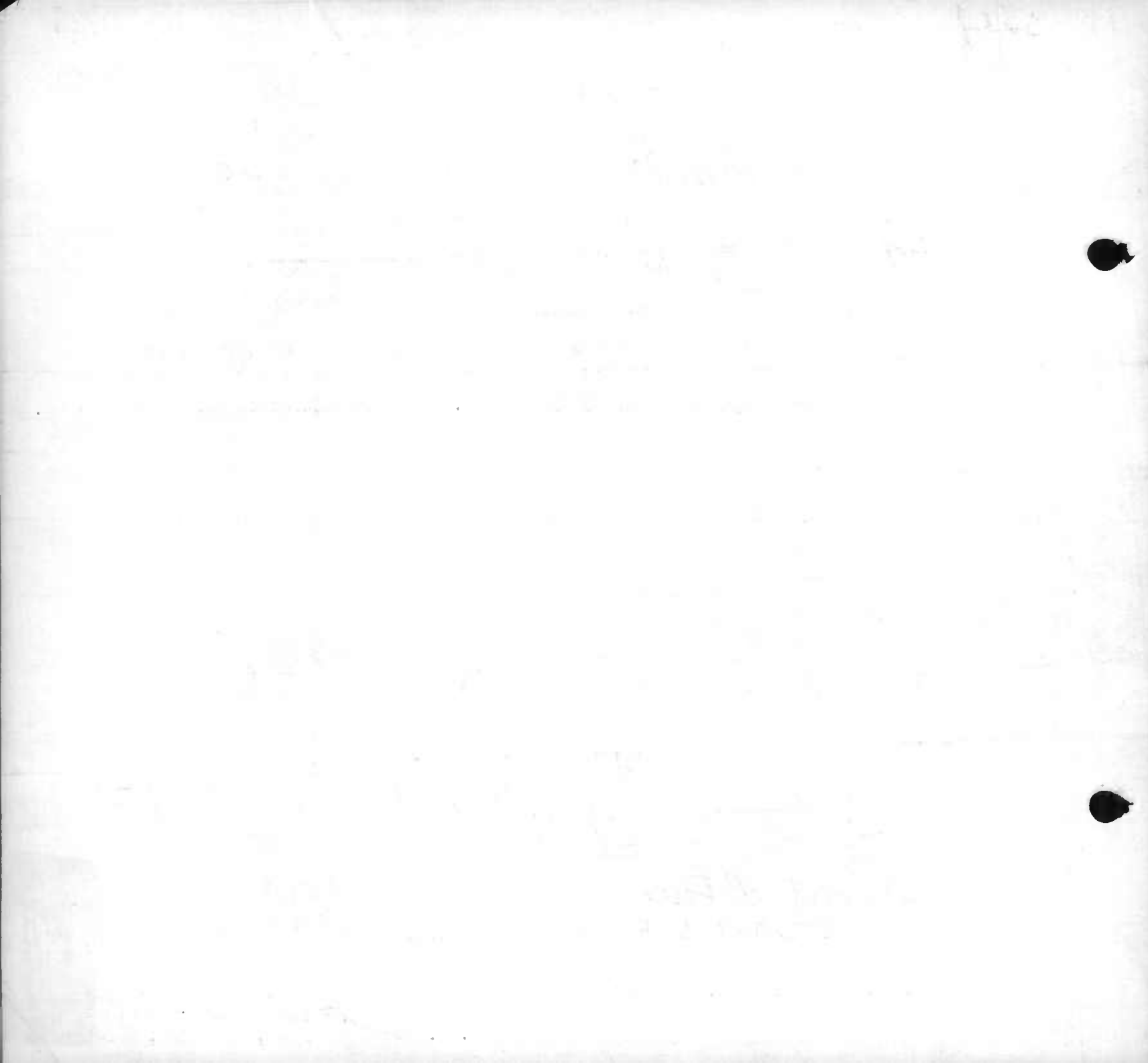
THURSDAY 10/31/12

RECEIVED BY THE
JAMES A. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 2725	
BIRTH NO. 67 2725		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MITCHELL, JOHN	
2. DATE AND HOUR OF DEATH 3/17/67 1400 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSPITAL 38		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Frederick Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) MYERSVILLE 60-00 D. STREET ADDRESS (If rural, give location) Route # 1			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 3/9/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Newspaper Business		11. BIRTHPLACE (State or foreign country) SCOTLAND	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME JOHN MITCHELL			
14. MOTHER'S MAIDEN NAME Jessie A. Keith		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No UNKNOWN			
16. SOCIAL SECURITY NO. 059 03 8500		17. INFORMANT ADDRESS Mrs. Jane Mitchell, Route #1, Myersville, Md.			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) CARDIOGENIC SHOCK DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CHRONIC MYOCARDITIS DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/2/67 19 to 3/17/67 19 that (I) (we) last saw the deceased alive on 3/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stuart L. Fine		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/17/67	
23C. PHYSICIAN'S NAME (Type) STUART L. FINE		23D. ADDRESS M.D. UNIV. HOSP. BALTO. 1, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 20, 67		24C. NAME of CEMETERY or CREMATORY Mount Olivet Cemetery	
24D. LOCATION Frederick, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Donald M. Fadley			
M. R. Etobison & Son, Frederick, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

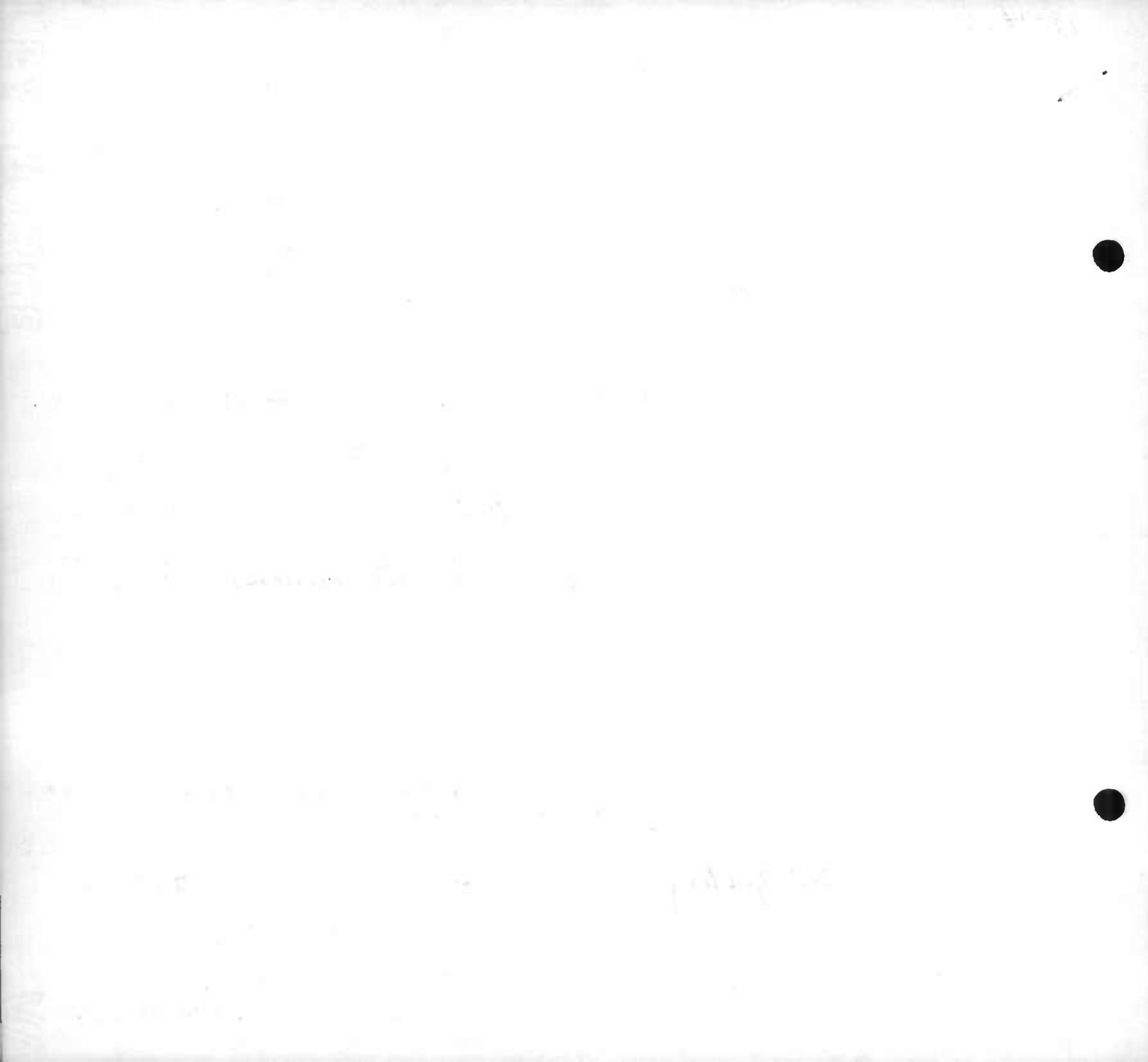
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2726	
BIRTH NO. 67 2726				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED	
(Type or Print)				YETTA GROSSMAN	
2. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
00 3414 OLYMPIA AVENUE				MARYLAND	
5. SEX				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FEMALE				BALTIMORE	
6. RACE				D. STREET ADDRESS (If rural, give location)	
WHITE				3414 OLYMPIA AVENUE	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH	
WIDOW				MARCH 17, 1967	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years lost birthday)	
HOUSEWIFE				88	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
AT HOME				POLAND	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
NATHAN FLUM				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME	
NO				MAILKA ?	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
UNKNOWN				MRS. OSCAR ROBERTS, 3414 OLYMPIA AVENUE #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1966</u> to <u>March 17, 1967</u> , that (I) was last saw the deceased alive on <u>March 17, 1967</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Nathan B. Needle</u> M.D.				3/17/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. NATHAN NEEDLE				6506 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		3/19/67		WORKMEN CIRCLE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 21 1967		<u>Robert E. Taylor</u>		SOL LEVINSON & BROS. INC., 6010 REIST., RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2727	
BIRTH NO. 67 2727		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SIMON (SAM) HOLZMAN			2. DATE AND HOUR OF DEATH Sat March 18, 1967 4 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3618 Forest Park Ave			A. STATE Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-38		
			D. STREET ADDRESS (If rural, give location) 3618 Forest Park Ave.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harry Holzman			14. MOTHER'S MAIDEN NAME Faggie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 123/20/7689	17. INFORMANT ADDRESS Mrs. Sarah Holzman-- 3618 Forest Park Ave.		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			1A) DUE TO CHF 2 days		
ANTECEDENT CAUSES			1B) DUE TO ASD 4 years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			1C) Uremia 2 days		
			D Diabetes Mellitus 10 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5/4 1950 to 3/18 1967, that (I) (we) last saw the deceased alive on 3/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Israel Zinberg			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/19/67
23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG			23D. ADDRESS M.D. 4000 Northern Parkway		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE Mar 19, 1967	24C. NAME of CEMETERY or CREMATORY Tifereth Israel Anshe	24D. LOCATION (City, town, or county) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Zinberg	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2728	
BIRTH NO. 67 2728				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Stauch, Ernest		2. DATE AND HOUR OF DEATH 3-20-67 2:45 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION Dukeland Nursing + Convalescent Home		(If not in hospital or institution, give street address or location)		B. COUNTY BALTIMORE	
5. SEX M		6. RACE W		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 4-01	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 12-6-90		9. AGE (In years lost birthday) 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Ind.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Stauch		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ✓		16. SOCIAL SECURITY NO. ✓		17. INFORMANT Dukeland nursing home ADDRESS 1501 Dukeland St.	
18. 42211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MASSIVE PULMONARY EMBOLISM DUE TO (B) GENERALIZED ARTERIOSCLEROTIC CHANGES DUE TO (C) CHRONIC HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 10 HRS 28 YRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		FRACURE R. HIP (NAILED)		Nov 66	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from 18 Jan 67 to 20 Mar 67 , that (I) we last saw the deceased alive on 24 Mar 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) W (did) did not view the body after death.					
23A. SIGNATURE E. W. Wilson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 20 Mar 67	
23C. PHYSICIAN'S NAME (Type) Emerson B. Wilson		M.D. ADDRESS 2329 HARLEM Ave Baltimore		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) 4300 Old Federal Rd.		(State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR John J. Cowan + Son Inc.		ADDRESS 93 Mt. St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>56-48-44</u>				
BIRTH NO. <u>67 2729</u>					DATE AND HOUR OF DEATH <u>March 16, 1967</u> <u>9:25 P.M.</u>				
M.E. CASE NO. <u>1</u>					NAME OF DECEASED <u>Hintemach, Mary Wilfrid</u>				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE <u>Maryland</u>				
<u>44 UNION MEMORIAL HOSPITAL</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>27-01</u>				
					D. STREET ADDRESS (If rural, give location) <u>4110 Harris Avenue</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>07-23-01</u>	9. AGE (In years lost birthday) <u>65</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>William Kirwin</u>			14. MOTHER'S MAIDEN NAME <u>Mary Craddock</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Raymond Hintemach</u> ADDRESS <u>4110 Harris Ave</u>				
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(A) <u>ACUTE MYOCARDIAL INFARCTION</u>			<u>3 DAYS</u>	
ANTECEDENT CAUSES					(B) <u>HYPERTENSIVE CARDIO-VASCULAR DIS.</u>			<u>10-15 YEARS</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>ACUTE Cerebro-Vascular Accident WITH RIGHT HEMIPLEGIA</u>			<u>3 DAYS</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>March 14, 1967</u> to <u>March 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 16, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Robert W. Garris</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>March 16, 1967</u>				
23C. PHYSICIAN'S NAME (Type) <u>ROBERT W. GARRIS</u>					23D. ADDRESS <u>12 EAST EAGER ST. BALTIMORE MD. 21202</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/21/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkes</u>		25C. FUNERAL DIRECTOR <u>Union Memorial Home</u>		ADDRESS <u>4210 Belair</u>			

8-2-68

2-2-68

March 1968

March 1968

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 Baltimore

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

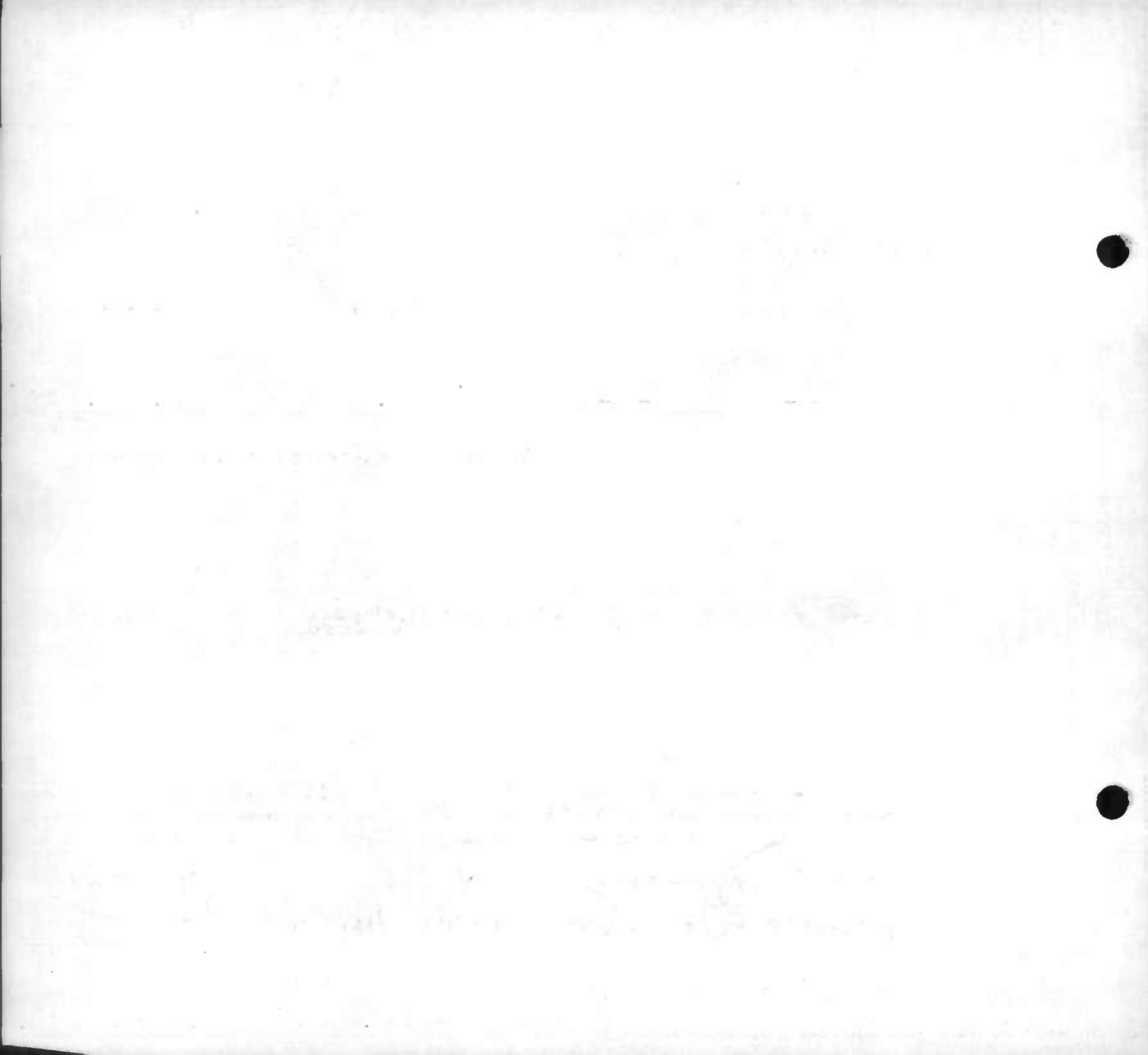
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 2730					REGISTERED NO. 67 2730				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) JEANNETTE FALKENSTEIN					2. DATE AND HOUR OF DEATH MAR. 20, 1967 7:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2006 PORTUGAL ST. 00 BALTO. MD. 21231					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21231 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 2-01 D. STREET ADDRESS (If rural, give location) 2006 PORTUGAL ST.				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-2-12	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER			10B. KIND OF BUSINESS OR INDUSTRY A.F. GOETZE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH STANCZYK			14. MOTHER'S MAIDEN NAME ANTOINETTE MIKICKA						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-05-8395		17. INFORMANT JOHN FALKENSTEIN		ADDRESS 6930 GOUGH ST. BALTO. MD. 21224		
18. 133.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma Gall Bladder					CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Metastatic Carcinoma							6 mos		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1961 to 3-20-67 19 to 3-20-67 19 that (I) (we) last saw the deceased alive on 3-14-67 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Theodore T. Niznik					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-20-67		
23C. PHYSICIAN'S NAME (Type) T. T. NIZNIK			23D. ADDRESS M.D. 429 S Chester St						
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-22-67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM.			24D. LOCATION (City, town, or county) (State) BALTO. CO. MD.		
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967			25B. NAME OF REGISTRAR Paul E. Fisher, M.D.			25C. FUNERAL DIRECTOR W. FIALKOWSKI			
ADDRESS 2007 EASTERN AVE. BALTO. MD. 21221									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2731		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2731	
1. NAME OF DECEASED (Type or Print) Esther B. Gross			2. DATE AND HOUR OF DEATH 3-18-67 5 A.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto Co.		
FULL NAME OF HOSPITAL OR INSTITUTION Gould Convalesarium			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6116 Bel Air Road			D. STREET ADDRESS (If rural, give location) 7917 Rolling View Ave. 21236		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/20/1879	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Churchville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Nagle			14. MOTHER'S MAIDEN NAME Elizabeth Hutcheson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ---		16. SOCIAL SECURITY NO. 216-50-0103	17. INFORMANT Mrs. William M. Magness ADDRESS 7917 Rolling View Ave. Balto., Md. 21236		
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rectal bleedings, etiology unknown		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to March 18 1967 , that (I) (we) last saw the deceased alive on March 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Ronald Wandorf			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-18-67
23C. PHYSICIAN'S NAME (Type) Ronald Wandorf			23D. ADDRESS 6077 Harford Rd		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/1967		24C. NAME of CEMETERY or CREMATORY Centre	
24D. LOCATION Forest Hill, Maryland		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Charles E. Jarrett		25C. FUNERAL DIRECTOR Charles E. Kurtz ADDRESS Jarrettsville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2732				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2732	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Warner, Charles Raymond</i>				2. DATE AND HOUR OF DEATH <i>March 14-1967 3 P. M.</i>			
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 2609 - Greenmount Ave Baltimore 21218, Md</i>				A. STATE <i>Maryland</i> B. COUNTY <i>21218</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 9-04</i>			
				D. STREET ADDRESS (If rural, give location) <i>2609 - Greenmount Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Dec 1, 1904</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H & B Bakery</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Delivering Bread & Pies</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-03-2677</i>		17. INFORMANT <i>Mrs Beverly Williams</i>	
				ADDRESS <i>1306 J Linit Ave, Balto 21212, Md</i>			
18. <i>5-81.0 I</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>Cirrhosis of Liver</i>		<i>months?</i>	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Malnutrition</i>		<i>months?</i>	
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>March 1, 1967</i> to <i>March 14, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 14, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Frank N. Ogden</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>March 17, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>FRANK N. OGDEN</i> M.D.				23D. ADDRESS <i>2701 N. Calvert St</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>March 18, 1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Madewoodge</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE RECD BY HEALTH DEPT. <i>MAR 21 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Tabor, MA</i>		25C. FUNERAL DIRECTOR <i>Earl B. Woberton Funeral Home Inc 6306 - Belair Rd., Baltimore 21206, Md</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2733	
BIRTH NO. 67 2733		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 3-16-67 8:30 P.M.	
1. NAME OF DECEASED (Type or Print) WILLIE VIRGINIA PIET		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balto Co.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rnal Balto Co. 53-00	
		D. STREET ADDRESS (If rural, give location) STELLA MARIS HOSPITAL	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 10-5-78
		9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ambrose Piet.	
14. MOTHER'S MAIDEN NAME Virginia Porter		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospt. Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive Hemoptysis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Saccular Bronchiectasis, Severe			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/3/67 19 67 to 3/16 19 67 , that (I) (we) last saw the deceased alive on 3/16/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael A. Ellis		23B. DATE SIGNED 3-17-67	
23C. PHYSICIAN'S NAME (Type) Michael A. Ellis		23D. ADDRESS Mercy Hospital Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/20/67	24C. NAME of CEMETERY or CREMATORY Cathedral Cem.	24D. LOCATION (City, town, or county) (State) Balto.
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967	25B. NAME OF REGISTRAR Robert E. Farber, M.D.	25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. 21212	

10. 10. 10.

11. 11.

12. 12.

13. 13.

14. 14.

15. 15.

16. 16.

17. 17.

1
B-210 67 2734

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2734

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Clarence H. BUZBY

2. DATE AND HOUR PRONOUNCED DEAD

March 18, 1967

2:43 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27-02
2920 Overland Ave.

5. SEX

M.

6. RACE

W.

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 23, 1945

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Attendant

10B. KIND OF BUSINESS OR INDUSTRY

Service Station

11. BIRTHPLACE (State or foreign country)

New Mexico

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John T. Buzby

14. MOTHER'S MAIDEN NAME

Thersa Osgood

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1962-1965

16. SOCIAL
SECURITY NO.

214-44-4021

17. INFORMANT

ADDRESS

John T. Buzby 920 E. 41st St.

18.

E823.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

on street - Walther Blvd.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

March, 18 67 1:55

21E. INJURY OCCURRED

A. WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver of auto which hit pole

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
March 18, 196723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-21-67

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 21 1967

24B. NAME OF REGISTRAR

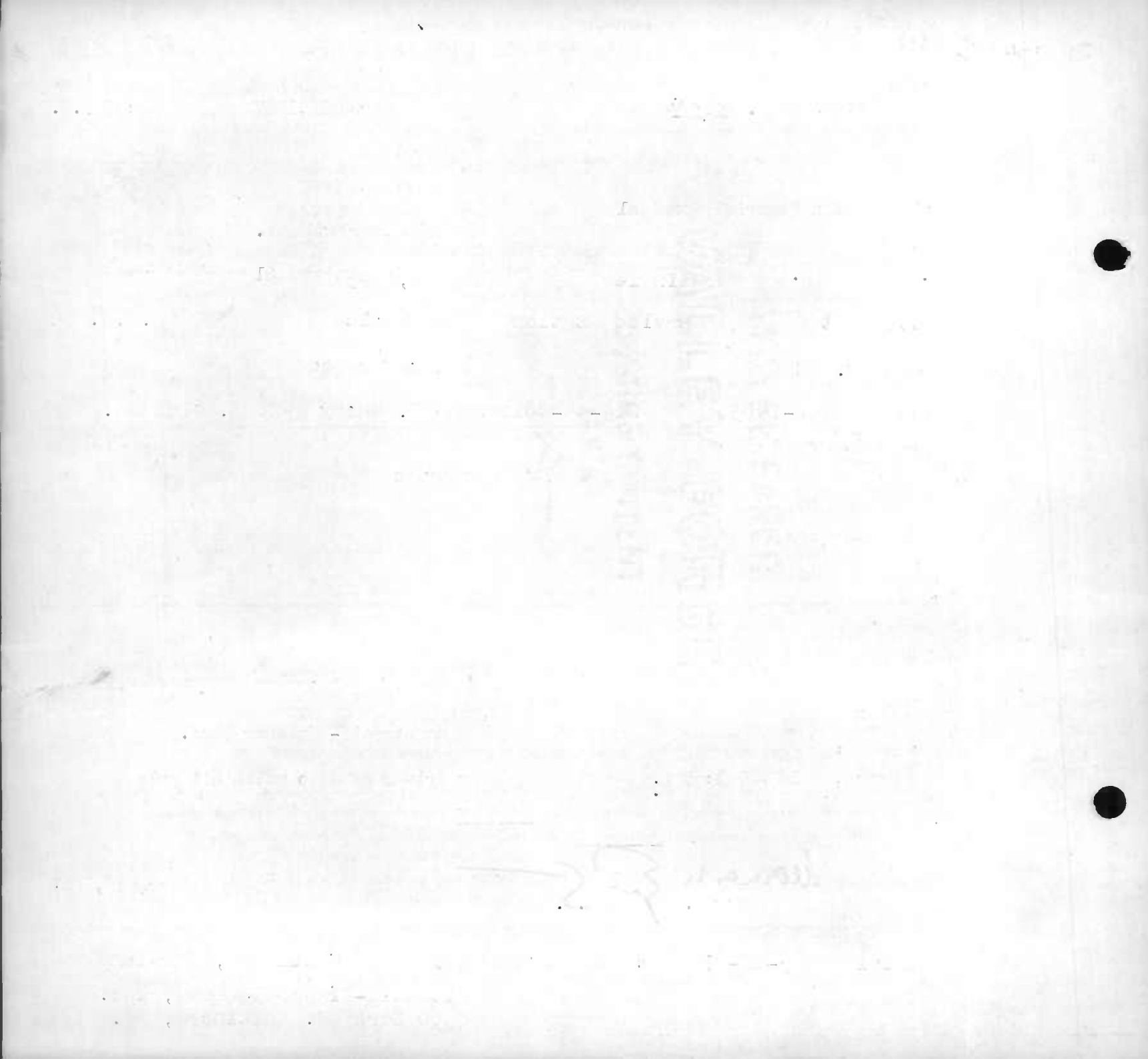
Robert E. Farley

24C. FUNERAL DIRECTOR

Mitchell-Wiedefeld Home, Inc.

ADDRESS

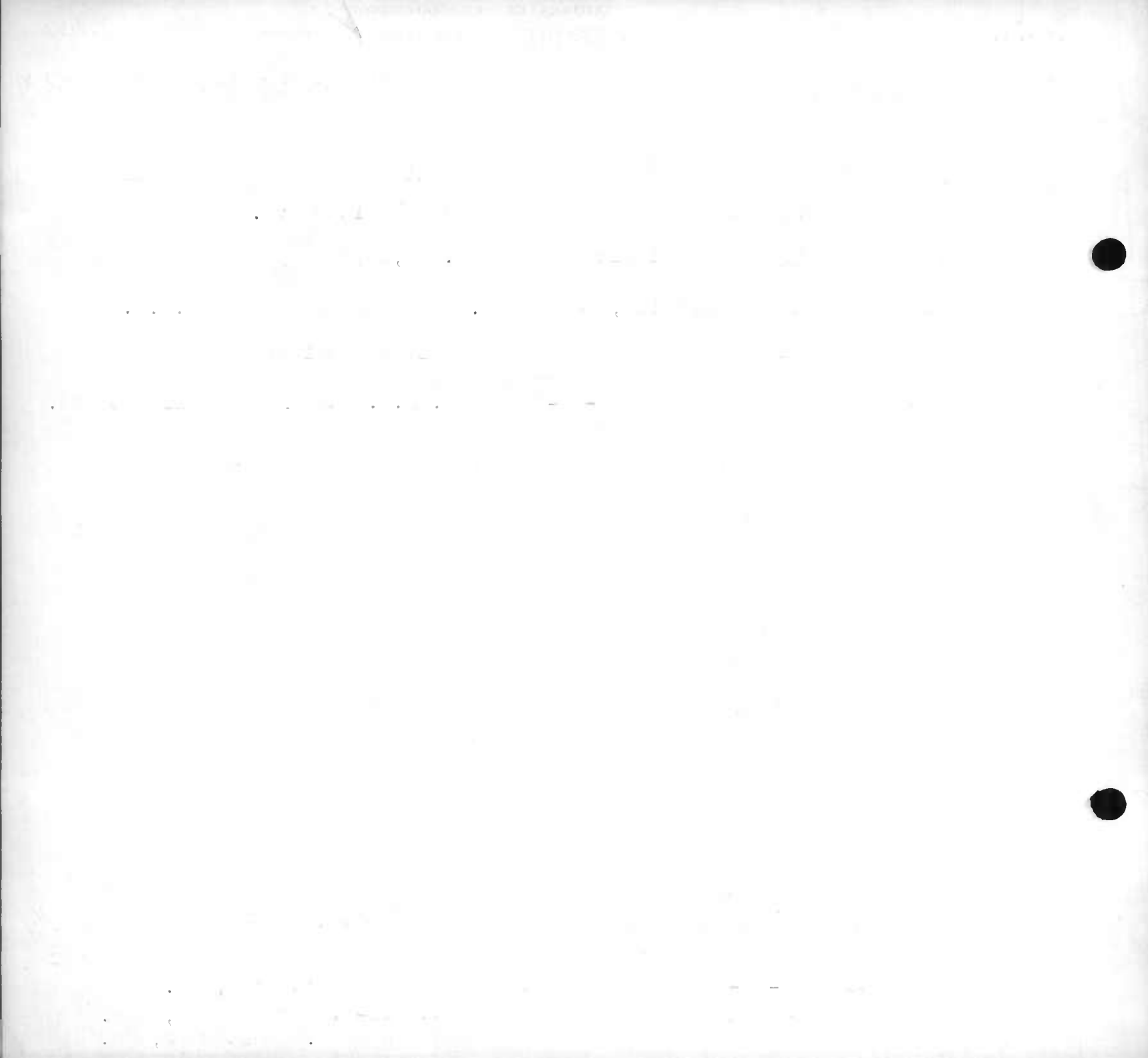
6500 York Rd. Baltimore, Md. 21212



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2735	
BIRTH NO. 67 2735		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George Lindeman	
2. DATE AND HOUR OF DEATH 18 MARCH 1967 10:00 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION House In the Pines - Bel Air		(If not in hospital or institution, give street address or location) 5837 Bel Air Rd. Baltimore, Md. 01206	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 509 Rossiter Ave.		27-10	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Aug. 14, 1873
9. AGE (In years last birthday) 93		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Manager		10B. KIND OF BUSINESS OR INDUSTRY Hoschild, Kohn & Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lindeman		14. MOTHER'S MAIDEN NAME Alvina Rudiger	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-8354	
17. INFORMANT Mrs. J.V. Stumph		ADDRESS 8710 Tilmont Ave.	
18. 7221 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Anterograde C-V Disease with heart failure		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Acute Terminal Pneumonia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH years 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Lauriston L. Keown		23B. DATE SIGNED 18 Mar 67	
23C. PHYSICIAN'S NAME (Type) Lauriston L. Keown		23D. ADDRESS 431 E. LAKE AVE BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3-22-67	
24C. NAME OF CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Baltimore, Md. 21212	



BIRTH NO.
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2736

1. NAME OF DECEASED (Type or Print)		EUGENE CARRINGTON		2. DATE AND HOUR PRONOUNCED DEAD March 20, 1967 3:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland B. COUNTY	
00 522 N. Monroe Street				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-01	
D. STREET ADDRESS (If rural, give location) 522 N. Monroe Street					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday) 43	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY Gen Contractor		11. BIRTHPLACE (State or foreign country) South Boston - VA	
13. FATHER'S NAME CHARLES CARRINGTON			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME PAULINE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 22-24-8103		17. INFORMANT ADDRESS BETTY CARRINGTON 522 N. Monroe St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Liver. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21F. HOW DID INJURY OCCUR?					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/20/67					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE 3/25/67		23C. NAME of CEMETERY or CREMATORY Mt Auburn	
23D. LOCATION (City, town, or county) (State)		Baltimore			
24A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		24B. NAME OF REGISTRAR R. E. Farley		24C. FUNERAL DIRECTOR Trans Am Funeral Home 638 N. Monroe St	

[illegible]

Dear Sirs,

The end of the world is near.

BIRTH NO. 67 2737

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ERNESTINE YVETTE PAGE

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1967

9:35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 724 Carrollton Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

724 Carrollton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7-25-1966

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

7

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Hawkins

14. MOTHER'S MAIDEN NAME

Charity Page

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Charity Page 724 Carrollton Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Pneumonia (SDII).
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

3/16/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 21 1967

Robert E. Jenkins

Marion P. Hayes 638 N. Gilman St



W-300

67 2738

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2738

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROY J. WHITE

2. DATE AND HOUR PRONOUNCED DEAD

3-14-67

8:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1324 EUTAW PLACE - Off. Steve Danko

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1324 Eutaw Place - 21201

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

3/29/1932

9. AGE (in years
last birthday)

33-34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLOTHES HELPER BEDDING MAKER.

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES WHITE

14. MOTHER'S MAIDEN NAME

LILLIE WHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-28-1194

17. INFORMANT

ADDRESS

LILLIE WHITE 445 WALTON CT.

18.

982X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Stab wound of chest, involving heart

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

HOME

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1324 Eutaw Place

11-04

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 ? 67 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-15-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/15/67

23C. NAME of CEMETERY or CREMATORY

NOT AUBURN

23D. LOCATION

(City, town, or county)

(State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 21 1967

Robert E. Fisher

Fisher & Sons 138 E. Green St

MAILED 1898

JULY 1898

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Robert Mickle

2. DATE AND HOUR PRONOUNCED DEAD

3-18-67

3:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1504 W. Fayette St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1504 W. Fayette St

5. SEX

M

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov 7-1925

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Of kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Gen Contractor

11. BIRTHPLACE (State or foreign country)

Richland Co., S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARDELL MICKLE

14. MOTHER'S MAIDEN NAME

MINERVIE PINKNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

250324682

17. INFORMANT

ADDRESS

Nancy Farnell 1504 W. Fayette St

18.

E982X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Massive Internal bleeding

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

stab wound of chest involving

(C) DUE TO

Aorta + Inferior vena cava

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1504 W. Fayette St 19-02

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3-18-67 3:15 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner G. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-19-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

3/21/67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

COLUMBIA S.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 21 1967

Werner G. Spitz

Marshall P. Ayers 638 N. Green St

no
 2000 West 10th Street
 Minneapolis, Minn.
 2000 West 10th Street
 Minneapolis, Minn.
 2000 West 10th Street
 Minneapolis, Minn.

Remount 3/2/13
 Remount 3/2/13
 Remount 3/2/13
 Remount 3/2/13

S-636

67 2740

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 2740

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDITH MAE SHORTER

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1967

2:34 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

00 110 N. Stricker Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

110 N. Stricker Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widow

8. DATE OF BIRTH

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Mamie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

215-14-9457A

17. INFORMANT

ADDRESS

Georgia Fisher 1210 MYRTLE AVE

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALL
FLOOR

1134

Wagon

Man

Gravestone

no

Gravestone
Gravestone

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2741</u>	
BIRTH NO. <u>67 2741</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>POMPEY TUCKER</u>		2. DATE AND HOUR OF DEATH <u>3/17/67</u> <u>4:28</u> <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33 BALTIMORE, MD 21205</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		D. STREET ADDRESS (If rural, give location) <u>2814 WOODBROOK AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8-27-18</u>	9. AGE (in years lost birthday) <u>48</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>SPENCER Tucker</u>		14. MOTHER'S MAIDEN NAME <u>EMMA BARNES</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>227.05-9052</u>		17. INFORMANT <u>Frances Tucker</u>	
18. <u>692X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>GI bleeding</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>chronic uremia</u> <u>chronic glomerulonephritis</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> 19 <u>67</u> to <u>3/17</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Phillip L. Hall</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/17/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>PHILLIP L. HALL</u>		23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/21/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Pl. Baltimore</u>	
24D. LOCATION (City, town, or county) <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>William J. Phillips</u>		ADDRESS <u>1721 N. Mount</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2742		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2742	
M.E. CASE NO.		CERTIFICATE OF DEATH		2 30 - P M	
1. NAME OF DECEASED (Type or Print) MARNER, EVA E.		2. DATE AND HOUR OF DEATH 3/15/67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL OF MARYLAND		A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)		B. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		20-02	
		D. STREET ADDRESS (If rural, give location) 2530 W. FAIRMOUNT AVE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-22-18	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur Sedgwick		14. MOTHER'S MAIDEN NAME Lillian M.N. Unknaus	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-163901		17. INFORMANT Salvador Marner	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Subarachnoid Hemorrhage DUE TO (B) Cerebral Aneurysm DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 7 19 67 to March 15 19 67. that (I) (we) last saw the deceased alive on March 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Young Kil Kim		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-15-67	
23C. PHYSICIAN'S NAME (Type) Young Kil Kim		23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR William J. Phillips	
24G. DATE REC'D BY HEALTH DEPT. MAR 21 1967		24H. ADDRESS 1727 N. Mount			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2743		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2743	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Charles Harmon Bell Sr.		2. DATE AND HOUR OF DEATH 3-20-67 6:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MO. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1843 McHenry St.			
5. SEX M	6. RACE CAUS	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/14/96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Auto (Retired)		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
13. FATHER'S NAME William Bell		14. MOTHER'S MAIDEN NAME Maggie Snidt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 2387 A		17. INFORMANT Mrs Catherine J Bell, 1843 Mc Henry St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pulmonary embolus, main pulmonary artery (B) Status post fracture of right femur (head + neck of femur) (C)		INTERVAL BETWEEN ONSET AND DEATH hours 5 weeks	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES - PARTIAL	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) OUTSIDE of home on SIDE WALK	
21D. TIME OF INJURY (APPROX.) 2-14-67-12 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL 19-04	
22. I certify that (H) (this hospital) attended the deceased from 3/20 19 67 to 3/20 19 67, that (H) (we) last saw the deceased alive on 3/20 19 67 and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Morales		23B. DATE SIGNED 3/20/67		23C. PHYSICIAN'S NAME (Type) Jose Morales	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR THOMAS J. KENNY, INC		25D. ADDRESS Baltimore, Md.			

Don Secures Housing

12/14/90

1843

1843

12/14/90

1843

1843

1843

Don Secures Housing

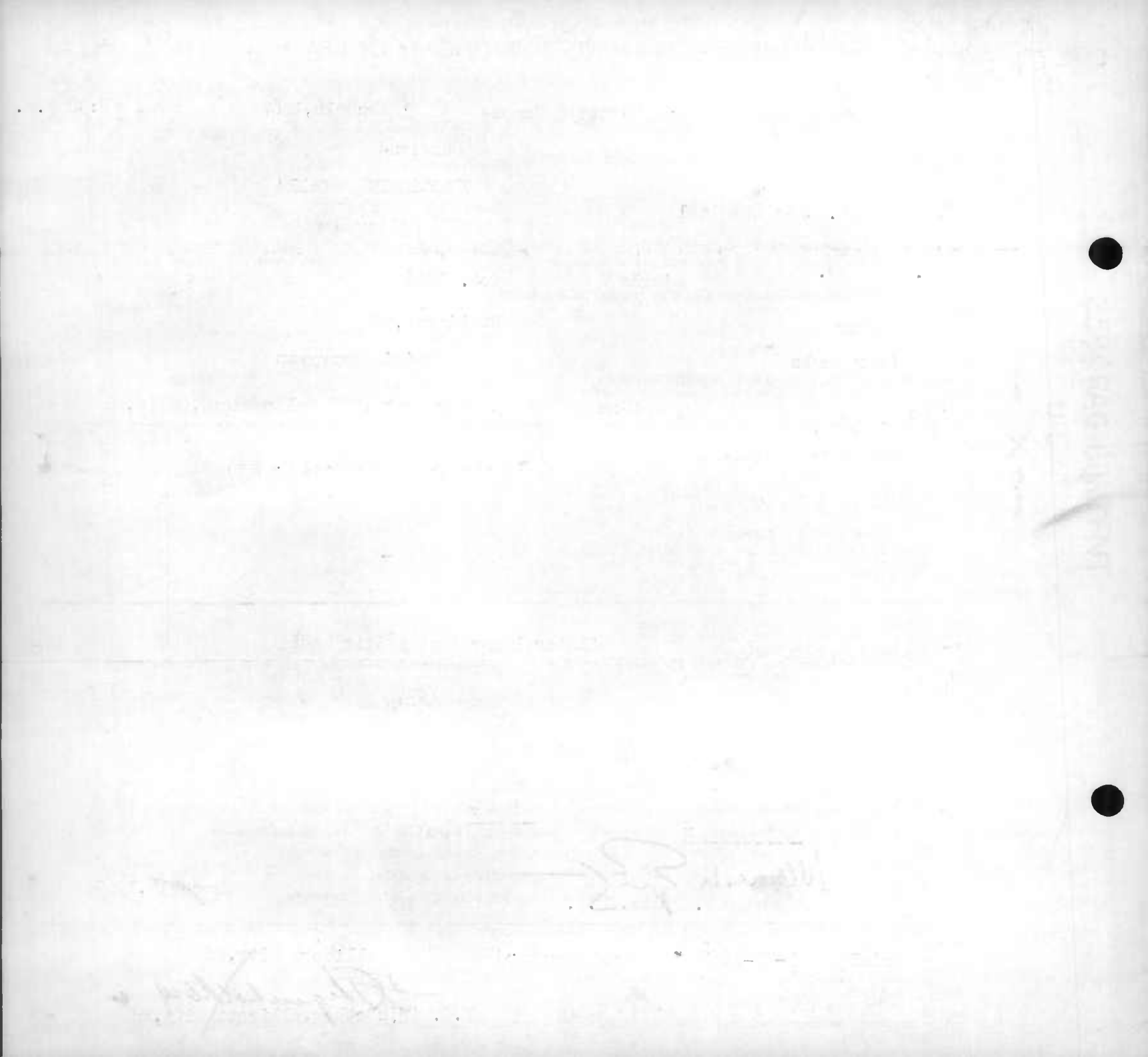
1843

Don Secures Housing

1843

1
C-512

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 2744	
BIRTH NO. 67 2744				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Randy Combs Randy Scott Combs				2. DATE AND HOUR PRONOUNCED DEAD March 18, 1967 8:38 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital				A. STATE Maryland B. COUNTY Balto. Co.			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Oella 53-00			
				D. STREET ADDRESS (If rural, give location) 778 Hollow Road			
5. SEX M.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Oct. 1966	9. AGE (In years last birthday) 5	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Omer Combs				14. MOTHER'S MAIDEN NAME Patricia Merryman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Omer Combs, 788 Hollow Road, Oella, Md			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Interstitital pneumonitis (SDII)							
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. bilateral purulent otitis media							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 18, 1967		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-21-1967		23C. NAME of CEMETERY or CREMATORY Good Shepherd		23D. LOCATION (City, town, or county) (State) Ellicott City, Md	
24A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		24B. NAME OF REGISTRAR Robert E. F. Johnson		24C. FUNERAL DIRECTOR F.C. Higginbotham		ADDRESS Ellicott City, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

46-21309 BIRTH NO. 67 2745		CERTIFICATE OF DEATH		Registered No. 67 2745	
1. NAME OF DECEASED (Type or Print) <i>Kevin J. Womack</i>			2. DATE AND HOUR OF DEATH <i>March 19 67 10 A M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 University Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>BALTO. Co.</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Dundalk</i> D. STREET ADDRESS (If rural, give location) <i>7607 Maple Road</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>12/26/66</i>	9. AGE (In years lost birthday) <i>3 months</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Willis Womack</i>			14. MOTHER'S MAIDEN NAME <i>Angelina Bianchi</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Chart</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>chronic congestive failure</i> DUE TO (B) <i>+ recurrent pneumonias</i> DUE TO (C) <i>20 to a single ventricle</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>12/26/66</i> to <i>3/19/67</i> 19 <i>66</i> to <i>3/19</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/19/67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Martha Leffer</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <i>March 19, 1967</i>	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS <i>University Hosp.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>3/21/1967</i>	24C. NAME OF CEMETERY or CREMATORY <i>oak lawn</i>	24D. LOCATION (City, town, or county) (State) <i>BALTO. Co., Md</i>		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>	25C. FUNERAL DIRECTOR <i>Walter Parks Bradley</i>		ADDRESS <i>Dundalk</i>

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. <u>67 2746</u>	
BIRTH NO. <u>67 2746</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>RICHARD KILLIAN VOLK</u>		2. DATE AND HOUR OF DEATH <u>MARCH 17, 1967</u> <u>7 45</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4 NORTH LAKEWOOD AVE.</u> <u>00 BALTIMORE, MD. 21224</u>		A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>4 NORTH LAKEWOOD AVE. 21224</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>JUNE 17, 1897</u>	9. AGE (In years last birthday) <u>79 YRS.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON MOLDER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>IRON PRODUCTS</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES VOLK</u>		14. MOTHER'S MAIDEN NAME <u>THERESA BIEFELD</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>SISTER - PAULINE HARTMAN - SAME</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>742X I</u> <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u> <u>PULMONARY EMPHYSEMA</u> <u>NEPHROSCLEROSIS</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>UREMIA; HEART BLOCK</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NONE</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>---</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>---</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>19 59</u> to <u>MAR. 17, 19 67</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 16, 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John F. Hartman</u>				23B. DATE SIGNED <u>March 20, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>John F. Hartman</u> <u>JAMES J. NOLAN</u>				23D. ADDRESS M.D. <u>1 MALLOW HILL RD. - BALTIMORE</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>March 20-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>			
25B. NAME OF REGISTRAR <u>R. E. F. F.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Supper Bros. Inc. 1800 E. Lombard St.</u>			

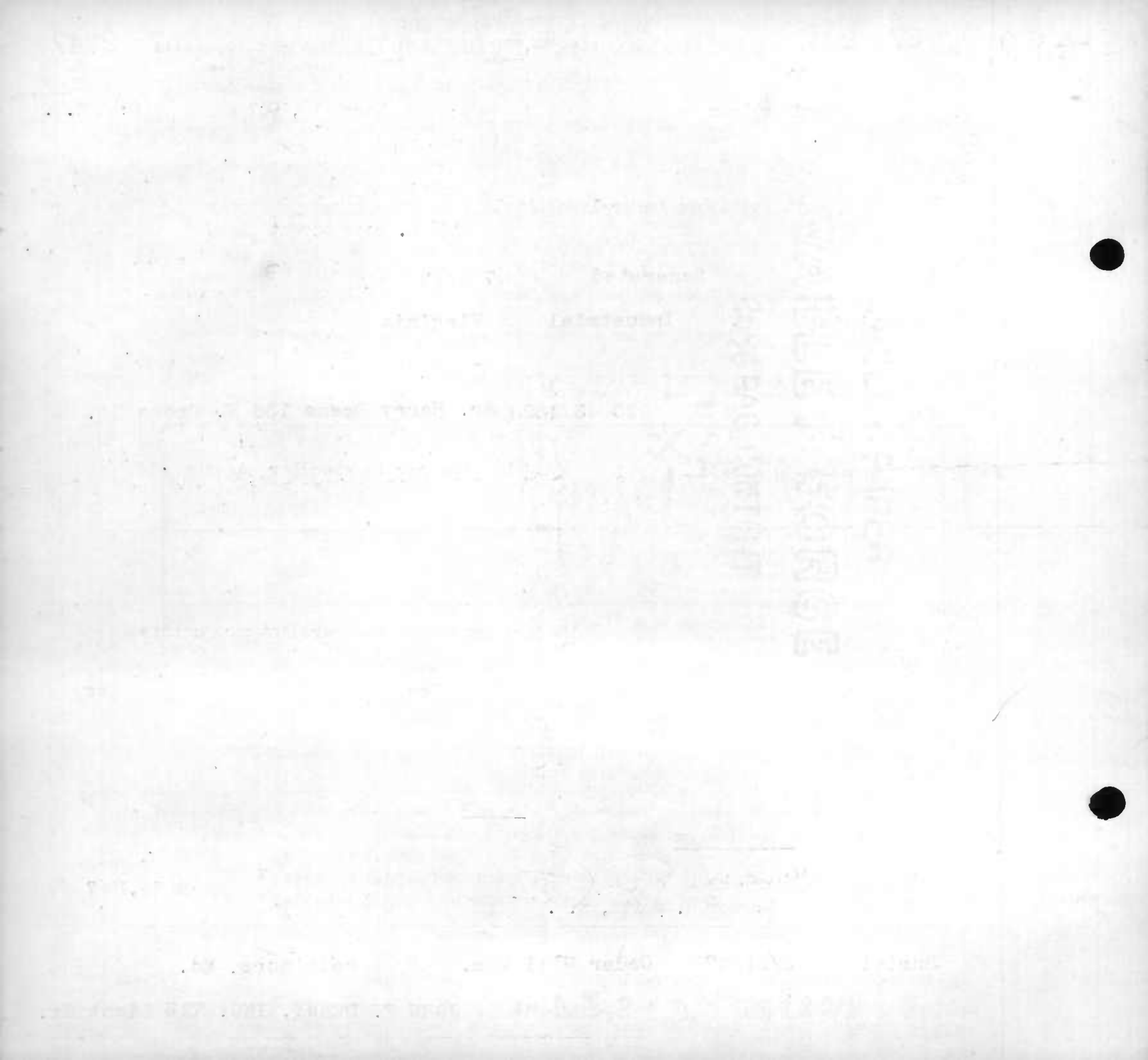
C-450

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2747

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Boyd Collawn		2. DATE AND HOUR PRONOUNCED DEAD March 18, 1967 8:40 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 138 E. Cross Street				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 7/8/97	9. AGE (In years last birthday) 69	10. If Under 1 Yr. Months, Days 11. If Under 24 Hrs. Hours, Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Industrial		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220 03 1828		17. INFORMANT ADDRESS Mr. Harry Deems 136 E. Cross St.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardio vascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Pulmonary emphysema and purulent bronchitis OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 19, 1967 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/21/67		23C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.		23D. LOCATION (City, town, or county) (State) Baltimore, Md.
24A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		24B. NAME OF REGISTRAR Robert E. Farber		24C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2748				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2748	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ISABELLE M. M. BARTON				2. DATE AND HOUR OF DEATH 3/18/67 3:00AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
<div>CERTIFICATE AMENDED</div> FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital (If not in hospital or institution, give street address and location) 3-39-67 48				A. STATE B. COUNTY Maryland Balto Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00			
D. STREET ADDRESS (If rural, give location) 2123 Southland Rd				5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widow	
8. DATE OF BIRTH 1/2/1908				9. AGE (In years lost birthday) 67 66		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Receptionist		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Arnold				14. MOTHER'S MAIDEN NAME Bertha Mayes Alverta Mayes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No none			
16. SOCIAL SECURITY NO. yes				17. INFORMANT Knightes		2123 Southland Rd. Balto			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Mrs Virginia Lee Hamilton		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Acute anterior myocardial infarction 12 hr					
				(B) DUE TO A.C.U.D					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3/17 19 67 to 3/18 19 67, that (I) (we) last saw the deceased alive on 3/18 19 67 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Samuel Goldner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/18/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 827 Linden Ave					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 21, 1967		24C. NAME of CEMETERY or CREMATORY Hereford Baptist Ch. Cemt. Hereford, Md.		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS STERLING FUNERAL ESTATE 236 Edm. Catonsville					

V.S. 153

3-30-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2749	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 2749 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED HERMAN (Type or Print) HERMAN, JOHN HENRY			2. DATE AND HOUR OF DEATH MARCH 17, 1967 6:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL 36			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND DUNDALK BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 22 DUNDALK D. STREET ADDRESS (If rural, give location) 8028 WALLACE ROAD 53-00		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10/26/1900	9. AGE (In years last birthday) 66	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRE DEPT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HERMAN, JOHN			14. MOTHER'S MAIDEN NAME WACKER, CAROLINA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 212013242		17. INFORMANT ADDRESS THERESA HERMAN 8028 WALLACE RD BALTO. 22 MD (WIFE)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) 18. CAUSE OF DEATH CARCINOMA OF SIGMOID			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/10 1967 to 3/17 1967, that (I) (we) last saw the deceased alive on 3/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas A. Alvero M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/17/67	
23C. PHYSICIAN'S NAME (Type) TOMAS A. ALVERO M.D.			23D. ADDRESS FRANKLIN SQUARE HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAR 21, 67		24C. NAME OF CEMETERY or CREMATORY MORELANDS	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967			
25B. NAME OF REGISTRAR John E. Farley		25C. FUNERAL DIRECTOR ADDRESS Connelly FH 300 more			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-540				Baltimore City Health Department		Registered No. 67 2750	
BIRTH NO. 67 2750		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALICE MANUEL		2. DATE AND HOUR OF DEATH 3-18-67		5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 256 S. Bouldin St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 27, 1884	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS JOHNS				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT WM. MANUEL		ADDRESS 258 S. BOULDIN	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebro-Vascular accident				few days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension; ABEVD							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-16 19 67 to 3-18 19 67 , that (I) (we) lost saw the deceased alive on 3-18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rodelio M. Lim M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/18/67	
23C. PHYSICIAN'S NAME (Type) Rodelio M. Lim M.D.				23D. ADDRESS Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/27/67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR Connelly J.H.		ADDRESS 300 W...	



1
C-200

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 2751		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2751	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) GUY COOK		2. DATE AND HOUR PRONOUNCED DEAD March 17, 1967 2:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 308 S. Macon St. 00		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 308 S. Macon St. 26-07	
5. SEX M.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH SEPT. 28, 1890
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME EVERETT COOK		14. MOTHER'S MAIDEN NAME MARY ANN SPIVEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 266-16-0671	17. INFORMANT LULA COOK ADDRESS ABOVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 151X CARCINOMA OF STOMACH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3. 18. 67	
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23B. DATE 3/21/67	23C. NAME of CEMETERY or CREMATORY OAK LAWN	23D. LOCATION (City, town, or county) (State) BALTO. MD
24A. DATE REC'D BY HEALTH DEPT. MAR 21 1967	24B. NAME OF REGISTRAR Robert E. Farley, MD	24C. FUNERAL DIRECTOR CONNELLY SONS	ADDRESS 300 MACE

10.1.1

2017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

KALYNYCH

2. DATE AND HOUR PRONOUNCED DEAD

March 19, 1967

5:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Dundalk

D. STREET ADDRESS (If rural, give location)

7939 St. Monica Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

8/13/25

9. AGE (in years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Const. Work

10B. KIND OF BUSINESS OR INDUSTRY

F. T. Asher & Sons

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Maxim Kalynych

14. MOTHER'S MAIDEN NAME

Eva Kolumber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Navy

16. SOCIAL
SECURITY NO.

211-12-4212

17. INFORMANT (Wife)

Rosemary Kalynych, 7939 St. Monica Dr.

ADDRESS

Dundalk, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/20/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/23/67

23C. NAME of CEMETERY or CREMATORY

Sacred Heart of Jesus Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

John J. Duda 7922 Wise Ave. Dundalk, Md.

WILLIAM J. COLE

[Signature]
WILLIAM J. COLE

WILLIAM J. COLE

WILLIAM J. COLE

WILLIAM J. COLE

WILLIAM J. COLE

BIRTH NO. 53067 2753		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Bette Lamons Smith</i>		2. DATE AND HOUR OF DEATH <i>3/19/67 11:50 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore C.</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE - Dundalk 53-00</i>		D. STREET ADDRESS (If rural, give location) <i>8013 Park Haven Road 21222 005</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>1-8-28</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>School</i>	9. AGE (In years last birthday) <i>39</i>
11. BIRTHPLACE (State or foreign country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward G. Lamons</i>		14. MOTHER'S MAIDEN NAME <i>Sadie English</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>410-30-8591</i>	
17. INFORMANT <i>RECORDS: BCH 4940 Eastern Ave.</i>		ADDRESS <i>21224</i>	
18. <i>331A I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Intracerebral bleeding</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) <i>none</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>3/19/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intracerebral bleeding</i>	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/19 67</i> to <i>3/19 67</i> that (I) (we) last saw the deceased alive on <i>3/19 67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Franklin G. Straus</i> M.D.		23B. DATE SIGNED <i>3/19/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>FRANKLIN G. STRAUS</i> M.D.		23D. ADDRESS <i>BCH 4940 Eastern Avenue #21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/22/67</i>	
24C. NAME of CEMETERY or CREMATORY <i>Oak Grove Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Greensville, Tenn.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 21 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>John J. Duda</i>		ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2754</u>	
BIRTH NO. <u>67 2754</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LEEF, JOHN</u>		2. DATE AND HOUR OF DEATH <u>3/17/67</u> <u>7:00 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>48</u> <u>MARYLAND General Hospital</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Reisterstown Md</u> 53-00	
5. SEX <u>MALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown. Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>MAY 8, 1887</u>	
13. FATHER'S NAME <u>JOHN G. LEEF</u>		14. MOTHER'S MAIDEN NAME <u>ALMAN</u>		9. AGE (In years last birthday) <u>79</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-9094</u>		17. INFORMANT <u>admission record</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>myocardial infarction</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>11</u>	
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u> <u>precurvia, cerebral vascular accident</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>none</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>none</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> 19 <u>67</u> to <u>3/17</u> 19 <u>67</u> that (I) <u>we</u> last saw the deceased alive on <u>3/17</u> 19 <u>67</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Fred R. Eiber</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/17/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRED R. EIBER</u>		23D. ADDRESS <u>MARYLAND General Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/20/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Pleasant Grove</u>	
24D. LOCATION (City, town, or county) (State) <u>Boring, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>			
25D. ADDRESS <u>Reisterstown, Md.</u>					

7/11/5

2437 7321

Wardland General

Wardland General

John R. Galt

Wardland General

22 HANCOCK

Wardland General

PT 21/12/50

412 W

Wardland General

Wardland General

Wardland

John R. Galt

Wardland General

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Wardland General

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2755

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Oscar Harley HARDY

2. DATE AND HOUR PRONOUNCED DEAD

March 19, 1967 8:00 A.M. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
ADDRESS OR LOCATION)3-21-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

2130 N. Pulaski St.

5. SEX

M

6. RACE

C7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)Married

8. DATE OF BIRTH

2/16/369. AGE (In years
last birthday)31If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Gas Station

11. BIRTHPLACE (State or foreign country)

Jamestown, S. C.12. CITIZEN OF
WHAT COUNTRY?USA

13. FATHER'S NAME

Moses Brown

14. MOTHER'S MAIDEN NAME

Isabelle Hardy15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)No16. SOCIAL
SECURITY NO.250-48-2090

17. INFORMANT

ADDRESS

Sarah Mae Hardy 2130 N. Pulaski St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carbon Monoxide Poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)Highway21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?6425 Pulaski Highway21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) 7:35
3 19 '67 AM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Found in auto-doors
locked, windows closed, motor running

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Werner U. Spitz, M.D.CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 19, 196723A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

3/23/67

23C. NAME of CEMETERY or CREMATORY

Family Lot

23D. LOCATION

(City, town, or county)

(State)

Jamestown, S. C.

24A. DATE REC'D BY HEALTH DEPT.

MAR 21 1967

24B. NAME OF REGISTRAR

Robert E. Frazier, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Nutter Funeral Home3035 W. North Ave.

WALLEY PERGE

ST. AUGUSTINE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2756		REGISTERED NO. 67 2756	
CERTIFICATE OF DEATH				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
George Ellis Rogers Sr				March 20, 1967		1:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 2317 W. Lafayette Ave				Maryland			
2317 W. Lafayette Ave				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
1605				Baltimore			
D. STREET ADDRESS (If rural, give location)				2317 W. Lafayette Ave			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		Colored		Married		April 12, 1872	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baker		Bakery		Danville, Virginia		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Malinda ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				212-18-3742		Mrs. Etta O. Rogers	
18. 420.01				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>Coronary Heart Failure</i> 3 months			
ANTECEDENT CAUSES				(B) <i>Arteriosclerotic Heart Disease</i> Unknown			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		(If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from March 7, 1967 to March 20, 1967, that (I) (we) last saw the deceased alive on March 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
Roland T. Smoot				3/20/67		23C. PHYSICIAN'S NAME (Type)	
ROLAND T. SMOOT,				23D. ADDRESS		3817 COPLEY RD., BALTO. 15, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/23/67		Mount Auburn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 21 1967		Herbert E. Nutter		3035 W. North Ave		3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2757</u>	
BIRTH NO. <u>67 2757</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>James Omar Jones</u>		2. DATE AND HOUR OF DEATH <u>3/18/67</u> <u>10: P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>			
		D. STREET ADDRESS (If rural, give location) <u>1311 Druid Hill Ave</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>6/5/1896</u>	9. AGE (In years lost birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Musician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Balto md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Henry Jones</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-1824-A</u>		17. INFORMANT <u>Chant & Lula P. Jones</u>	
				ADDRESS Ave. <u>1311 Druid Hill</u>	
18. <u>332X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Bronchopneumonia, bilateral</u> (A) DUE TO <u>Cerebral Infarct</u> (B) DUE TO <u>Arteriosclerotic cerebral vasculay disease</u> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/11/67</u> 19 to <u>3/18</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Daniel C Wilkerson</u>				23B. DATE SIGNED <u>3/18/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Daniel C Wilkerson</u>				23D. ADDRESS <u>421 Regester Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/22/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home-3035 W. North Ave</u>			
25D. ADDRESS <u>3035 W. North Ave</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 67 2758	
BIRTH NO. 67 2758		M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Irvin T. Beall				2. DATE AND HOUR OF DEATH March 19, 1967 5:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4400 Kavon Avenue						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-02 D. STREET ADDRESS (If rural, give location) 4400 Kavon Avenue					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4/18/1906		9. AGE (In years last birthday) 60		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10B. KIND OF BUSINESS OR INDUSTRY News Post		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas E. Beall						14. MOTHER'S MAIDEN NAME Elizabeth Rodrick					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 21201-7156		17. INFORMANT Mrs. Sarah H. Beall 4400 Kavon Ave.					
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) Arteriosclerotic Heart Disease DUE TO Heart Failure (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 11/7 1956 to 3/19 1967 , that (I) (we) last saw the deceased alive on 3/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Milton B. Kress M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED 3/20/67					
23C. PHYSICIAN'S NAME (Type) Milton B. Kress						23D. ADDRESS M.D. Med. Arts Bldg. Balto, Md. 21201					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John A. Moran, Inc.				ADDRESS 3000 E. Balto. St.			



1
D-250 67 2759

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2759

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FANNIE

DAWSON

2. DATE AND HOUR PRONOUNCED DEAD

March 19, 1967

10:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1500 W. Fayette Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3/3/25

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vat Watson

14. MOTHER'S MAIDEN NAME

Ananda Wiggins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ananda Wilson 1305 Myrtle Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/20/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/22/67

23C. NAME of CEMETERY or CREMATORY

Carver Memorial Pk.

23D. LOCATION

(City, town, or county)

(State)

Laurel, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 21 1967

Robert E. Farber

Charles A. Rice 661 W. Barre St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2760		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2760	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		ADAM F. KOZLOWSKI		2. DATE AND HOUR OF DEATH MAR. 19, 1967 1 24 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 1-03			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
		D. STREET ADDRESS (If rural, give location) 2436 FOSTER AVE.			
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/6/1887	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Joseph		14. MOTHER'S MAIDEN NAME MARY.		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-2158		17. INFORMANT MRS. J. ORZOLAK RT. 15 BOX 612-B.	
18. 42211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Arterioscl. C.V. Dis. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 57 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Generalized arterioscl.		10 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 19 to 3-17-67 19 that (I) was lost saw the deceased alive on 3-17-67 19 and that in (my) was opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.					
23A. SIGNATURE Ben R. Moses, MD		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-21-67	
23C. PHYSICIAN'S NAME (Type) BEN R. MOSES, MD		M.D.		23D. ADDRESS 448 N. LUZERNE AVE. BALTO. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/22/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem	
				24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR B. DABROWSKI 2814 F. BALTIMORE ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2761	
BIRTH NO. 67 2761		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILBUR C. GRAHAM		2. DATE AND HOUR OF DEATH March 18, 1967 3:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2605		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00 306 Gusryan St, Baltimore, 21224, Md.		D. STREET ADDRESS (If rural, give location) 306 Gusryan St. # 21224,			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec. 29, 1912	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY U.S. Mail		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Grover C. Graham		14. MOTHER'S MAIDEN NAME Anna Bosse	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. W. II		16. SOCIAL SECURITY NO. 212-01-6578		17. INFORMANT Dorothy M. Graham	
18. 136.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hepatic Carcinoma		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 mos 3 mos	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 01-17-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-27-66 19 to 3-18-1967 , that (I) (we) last saw the deceased alive on 3-3-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Edmonds M.D.				23B. DATE SIGNED March 21, 1967	
23C. PHYSICIAN'S NAME (Type) ROBERT W. EDMONDS M.D.				23D. ADDRESS 2045 YORK RD., TIMONIUM, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-67		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Ba. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Charles E. Taylor		25C. FUNERAL DIRECTOR 6224 Eastern Ave. Balto., 21224, Md.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2762		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2762	
M.E. CASE NO.		1. NAME OF DECEASED Niswander, Mrs Lydia A.		2. DATE AND HOUR OF DEATH March 18th 1967 9 P M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND Church Home and Hospital.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
5. SEX F		6. RACE W.		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Caldwell		12. CITIZEN OF WHAT COUNTRY? American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 230-09-8242		17. INFORMANT Mrs. Geneva Taylor	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Uremia 20 to 25 days		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Parcisona of the bladder 25 days		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-11 19 67 to 3-18 19 67, that (I) (we) last saw the deceased alive on March 18th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Dr. A. G. Subong, Jr.		23B. DATE SIGNED 3-18-67	
23C. PHYSICIAN'S NAME (Type) Dr. M. Feldman		23D. ADDRESS Church Home Hosp.		23E. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-67		24C. NAME of CEMETERY or CREMATORY Moreland Cemetery	
24D. LOCATION Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Twin Brook - Brooks Inc.		25D. ADDRESS 1217 St. Paul St.		25E. DATE SIGNED	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2763		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2763	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>McDermott, Catharine</i>		2. DATE AND HOUR OF DEATH <i>3-19-67 1:30 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balt. Co.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Towson</i>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>	
8. DATE OF BIRTH <i>7-5-25</i>		9. AGE (In years lost birthday) <i>41</i>		10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. BIRTHPLACE (State or foreign country) <i>WASHINGTON, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Vincent Bowdren</i>	
14. MOTHER'S MAIDEN NAME <i>Agnes Brennan</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>No.</i>	
17. INFORMANT <i>MR. JEROME McDermott</i>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>CARDIO-RESPIRATORY ARREST</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 min.</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>INCREASED INTRACRANIAL PRESSURE</i>		20. DUE TO (B) <i>METASTATIC CARCINOMA TO BRAIN.</i>		21. DUE TO <i>4 months.</i>	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CUSHING'S SYNDROME.</i>		23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>0 -</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> NO	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>March 18th</i> 19 <i>67</i> to <i>March 19</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 19th</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>Francisco Velasco</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-19-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Francisco Velasco</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
24B. DATE <i>3-22-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>RULANEY VALLEY CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>ROCKEYSVILLE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 21 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook - Brooks Towson</i>	
25D. ADDRESS <i>21204 YORK ROAD</i>		25E. ADDRESS <i>TOWSON MD, 21204</i>		25F. ADDRESS <i>TOWSON MD, 21204</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2764</u>	
BIRTH NO. <u>67 2764</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Elizabeth Miller</u>		2. DATE AND HOUR OF DEATH <u>3-16-67</u> <u>4:45</u> <u>a.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 701 Carey St.</u>		D. STREET ADDRESS (If rural, give location) <u>701 Carey St.</u>		16-01	
5. SEX <u>F</u>	6. RACE <u>Negroid</u>	7. MARRIED, NEVER MARRIED <u>Married</u>	8. DATE OF BIRTH <u>1-28-08</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Bethana Blackmon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>240099913</u>		17. INFORMANT <u>Thomas Blackmon 2709 Liberty Hgts.</u>	
18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>arterio sclerosis with hypertension 3-3-60 - 3-16-67</u> <u>Cerebral accident</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>3-3-60</u> 19 <u>60</u> to <u>3-16-67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-15-67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>John E. J. Camper</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3-20-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN E. J. CAMPER</u>		23D. ADDRESS <u>639 N. CAREY ST., BALTO., MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-20-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Pl.</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus Maryland</u>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Kelson Funeral Home 1348 Calhoun St.</u>	
25C. FUNERAL DIRECTOR ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2765				BALTIMORE CITY DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2765	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print)				Julia Carr		3-17-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
39 Provident Hospital				Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)		14-02			
				515 Mosher St.					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		Negroid		single		11-15-11		55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
Teacher				Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Dr. Wm. Carr Sr.				Julia Johnson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				215-16-0426		Dr. James Carr 3102 Hilton Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
43X1				Cerebral Thrombosis				43 days	
ANTECEDENT CAUSES				Hypertensive Cardiac Vascular Disease				7	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Jan 2 1966 to March 17 1967.				that (I) (we) last saw the deceased alive on March 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
F. K. Adams								3-21-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
F. K. ADAMS				M.D. 1222 N. Caroline St.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		3-21-67		New Cathedral Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 21 1967		G. E. Sullivan		Kolson Funeral Home		1348 Calhoun St.			

Charles C. Thompson
President of the
Board of Directors

James H. Thompson
Secretary

James H. Thompson
Secretary

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2766		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2766	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) COLLINS DAISY			2. DATE AND HOUR OF DEATH 3.18.67 9 05 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1804 Warwick Avenue		
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3/28/04	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC WORKER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME JONES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216140880	17. INFORMANT HARRISON		ADDRESS 1804 Warwick Avenue
18. 199.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO (B) OF LUNG AND BRAIN DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-2-11-1967 to 3-18-1967 , that (I) (we) last saw the deceased alive on 3-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Biswanath Pillai				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) V. BISWANATH PILLAI				23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-67		24C. NAME of CEMETERY or CREMATORY John Wesley Cem.	
24D. LOCATION (City, town, or county) Waterbury		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR John Wesley Cem.		25C. FUNERAL DIRECTOR Kelson Funeral Home	
				ADDRESS 1348 Calhoun St.	

10 NORTH HOSPITAL OF WASHINGTON
1800 NORTH HOSPITAL

2/24/21

U.S.

MD

1800 NORTH HOSPITAL

1800 NORTH HOSPITAL

9 METABOLIC CARBONATE

21 2000 AND 3000

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2-12-21
2-12-21

2-12-21

V BISHOP WITH PLEASANT
LUTHERAN HOSPITAL OF WASHINGTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2767				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2767		
1. NAME OF DECEASED (Type or Print) John Braxton				2. DATE AND HOUR OF DEATH 3-19-67 8 P. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 1455 Carey St.						
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-18-90	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 717093679		17. INFORMANT Marie Braxton 1455 Carey Street				ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) CAUSE OF DEATH Coronary occlusion (B) DUE TO Myocarditis (C)				INTERVAL BETWEEN ONSET AND DEATH 3 days 360 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initial medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 4-28-1965 to 3-19-1967, that (I) last saw the deceased alive on 3-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE John E. T. Camper				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-20-67				
23C. PHYSICIAN'S NAME (Type) JOHN E. T. CAMPER				23D. ADDRESS 439 N. CAREY ST. BALTO., MD.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-67		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR R. B. E. Taylor		25C. FUNERAL DIRECTOR Gelson Funeral Home		ADDRESS 1348 Calhoun St.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2768		CERTIFICATE OF DEATH		Registered No. 67 2768	
1. NAME OF DECEASED (Type or Print) <u>ALLAN HICKS</u>				2. DATE AND HOUR OF DEATH <u>3/14/67</u> <u>7:00 A</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>507 McNecken St.</u> <u>21217</u>					
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married-Sep.</u>		8. DATE OF BIRTH <u>6-21-03</u>		9. AGE (In years last birthday) <u>63</u>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eliza Hicks</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Gordy</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218090171</u>		17. INFORMANT ADDRESS <u>Daisey Waddy 1403 N. Longwood St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>593 x I</u> <u>PULMONARY EDEMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Renal Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>2 yrs. +</u>				CAUSE OF DEATH (A) <u>PULMONARY EDEMA</u> DUE TO (B) <u>Chronic Renal Failure</u> DUE TO (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (we) (this hospital) attended the deceased from <u>march 13</u> 19 <u>67</u> to <u>march 14</u> 19 <u>67</u> , that (we) last saw the deceased alive on <u>march 14</u> 19 <u>67</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Susan L. Howard MD</u>						23B. DATE SIGNED <u>3/14/67</u>		23C. PHYSICIAN'S NAME (Type) <u>M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-20-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>27707 Funeral Home 1348 Calhoun St.</u>					

47-88-73 1B

W-45267 2769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2769

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ida Williams

2. DATE AND HOUR OF DEATH

3-18-67 3 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1423 MYRTLE AVENUE - #21217

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

5-25-15

9. AGE (In years
lost birthday)

51

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOSHUA WRIGHT

14. MOTHER'S MAIDEN NAME

MATTIE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

230181635

17. INFORMANT

#21224 ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE

18.

170 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cardiopulmonary arrest

ANTECEDENT CAUSES

(B) DUE TO

Widespread metastatic

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) DUE TO

Carcinoma of breast

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-10-1966 to 3/18-1967,
that (I) (we) last saw the deceased alive on 3/18-1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Terry Ersel Gagon

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/18/67

23C. PHYSICIAN'S
NAME (Type)

DR. TERRY ERSEL GAGON

M.D.

23D. ADDRESS

BCH-4940 EASTERN AVENUE, BALTIMORE, MD

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

3-20-67

Arbutus Mem. Pk.

Arbutus

Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAR 21 1967

Kolston Funeral Home 1348 Calhoun St.

VS 150-REV. 11-7-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2770		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2770	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Neale, Samuel			March 19 67 5:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital University of Md.			A. STATE Md. B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 14-03		
			D. STREET ADDRESS (If rural, give location) 567 Prestman St.		
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/19/95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10B. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Samuel Neale		12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Mary Cole					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Henrietta Neale 567 Prestman St.	
18. I 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiovascular Collapse ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarct			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 72 h 96 h		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 3/16 19 67 to 3/19 19 67 , that (I) (we) last saw the deceased alive on 3/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (He) (did) (did not) view the body after death.					
23A. SIGNATURE David A. Shafritz M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/19/67	
23C. PHYSICIAN'S NAME (Type) David A. Shafritz M.D.				23D. ADDRESS Univ. Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-67		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert C. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.	

~~CONFIDENTIAL~~

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 27787 2771				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 67 2771	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Reginald Xavier Kirk, III</u>				2. DATE AND HOUR OF DEATH <u>3/18/67</u> <u>9:12 P.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore</u> <u>Belvedere & Greenspring</u> <u>Balto., Md. 21215</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>3922 Fairview Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>12/24/66</u>	9. AGE (In years last birthday) <u>2</u> <u>22</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>2</u> <u>22</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reginald Xavier Kirk, II</u>				14. MOTHER'S MAIDEN NAME <u>Linda Beatty</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Cecilia Williams</u>		ADDRESS <u>4508 Bonner Rd.</u>	
18. <u>754.7 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH A. <u>Acute congestive heart failure</u> DUE TO B. <u>congenital heart disease - transposition of the large arteries, mitral aortic insufficiency, inter-atrial septal defect</u> DUE TO C.		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u> <u>2 months - 22 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>0</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>0</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>0</u>			
21D. TIME OF INJURY (APPROX.) <u>0</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>0</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>March 8</u> 19 <u>67</u> to <u>March 18</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>March 18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Allan J. Monfried</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>March 18, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Allan J. Monfried</u>				23D. ADDRESS M.D. <u>Sinai Hospital of Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-21-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>		25B. NAME OF REGISTRAR <u>John E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Holston Funeral Home</u>		ADDRESS <u>1348 Calhoun St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2772	
BIRTH NO. 67 2772		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Harry F. Davis		2. DATE AND HOUR OF DEATH 3/16/67 10:45 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore.			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3408 Duvall Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 12/29/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Sugar Refining		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Everett Davis Edmund		14. MOTHER'S MAIDEN NAME Merchel Roberts	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Walter Davis ADDRESS Sons	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest		CAUSE OF DEATH (A) DUE TO Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Post Op thoracotomy			
19A. DATE OF OPERATION 3/13/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED finger fall Apex Lung		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) this hospital attended the deceased from 3/13 19 67 to 3/16 19 67 , that (I) (we) last saw the deceased alive on 3/16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A. F. Brooker Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/13/67	
23C. PHYSICIAN'S NAME (Type) A. F. Brooker Jr.		M.D. 23D. ADDRESS Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-67		24C. NAME OF CEMETERY or CREMATORY Not Calvary Cml	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR John A. J. J. J.	
25C. FUNERAL DIRECTOR Edward Wilson 1000 Broadway St		ADDRESS			



W-160

67 2773

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2773

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET

WEAVER

2. DATE AND HOUR PRONOUNCED DEAD

March 19, 1967

7:45 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

200 Aisquith Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Dec 9-1894

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

John Richardson

14. MOTHER'S MAIDEN NAME

Mary Brillard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Omar Wheeler Same

18.

4221

I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/20/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-24-67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cmt

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

MAR 21 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Chas Wilson Brantley Jr

ADDRESS

G-620

67 2774

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2774

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Viola Lillian Gross

2. DATE AND HOUR PRONOUNCED DEAD

3-18-67

4:19 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

218 N. Montford Ave

5. SEX

F

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widow

B. DATE OF BIRTH

Nov 26 - 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laundry

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John G. Hings

14. MOTHER'S MAIDEN NAME

Emma Polk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Charles H. Jettings

ADDRESS

Same

18.

157 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

CARCINOMA of PANCREAS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner L. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-19-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-23-67

23C. NAME of CEMETERY or CREMATORY

Dutchtown Cent

23D. LOCATION

(City, town, or county)

Brooklyn

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 21 1967

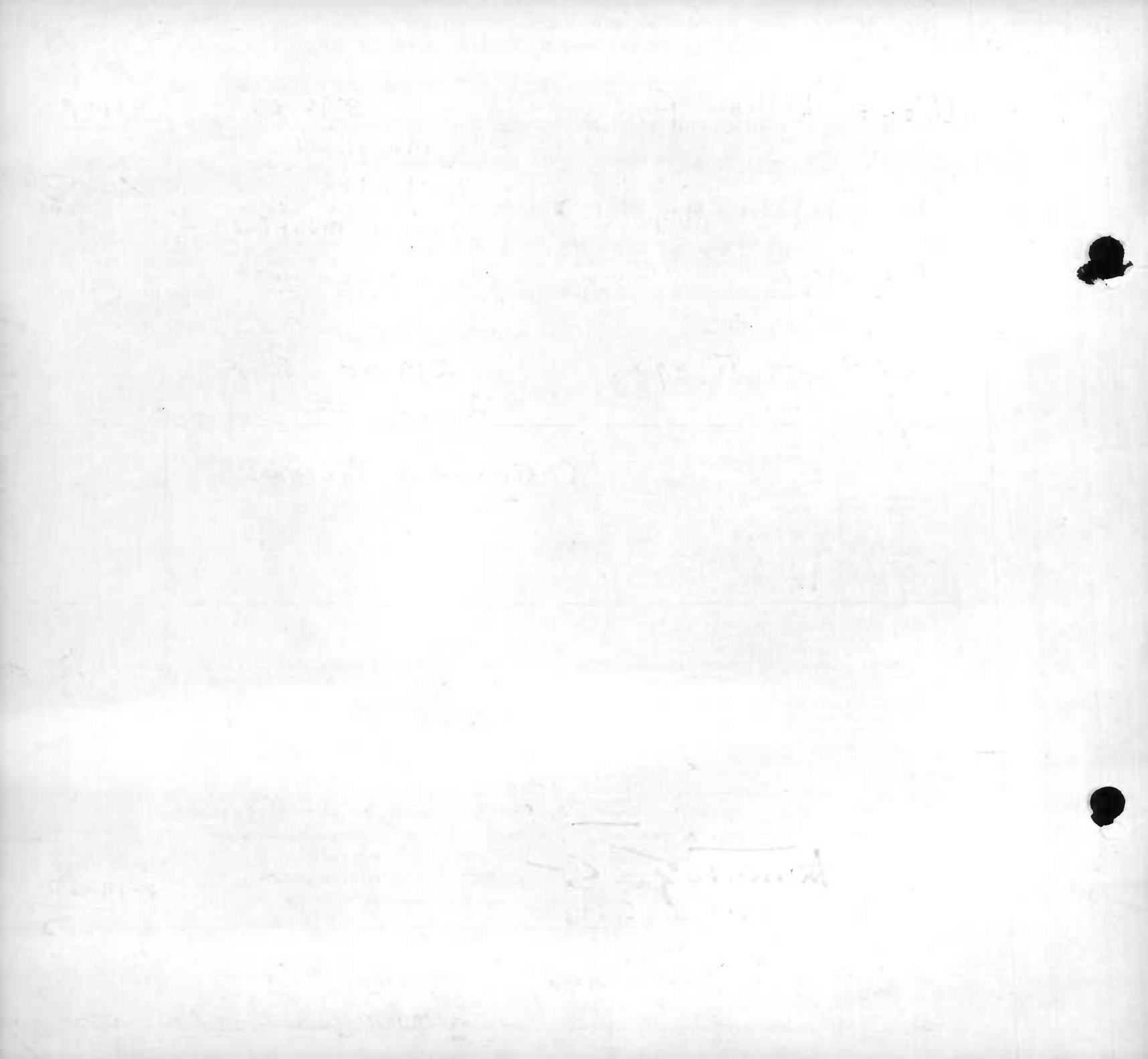
24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

George Wilson 1000 Brantley

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2775				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 105348	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Taylor Annie</u>				2. DATE AND HOUR OF DEATH <u>3-20-67 4:50 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>—</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hosp.</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1042 W. Saratoga St.</u>			
5. SEX <u>Fem.</u>	6. RACE <u>Col.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3-12-98</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Mannie Wallace</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Cluster Taylor</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>451X I</u>				CAUSE OF DEATH <u>Ruptured Aortic Abdom. Aneurysm 24 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Rejection Abdom Aneurysm</u>		<u>2/2/67</u>	
19A. DATE OF OPERATION <u>3-20-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured Aneurysm</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> 19 <u>67</u> to <u>3/20</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-20</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert W. McCurdy</u> M.D.				23B. DATE SIGNED <u>3-20-67</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert W. McCurdy</u>	
23D. ADDRESS <u>—</u> M.D.				23E. FUNERAL DIRECTOR <u>Gray & Wilson</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-23-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Airy Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert C. Taylor</u>		25C. FUNERAL DIRECTOR <u>Gray & Wilson</u>		ADDRESS	

1000 1000 1000

1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

67 2776

BALTIMORE CITY HEALTH DEPARTMENT

67 2776

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Dr. Jaime Renato Guzman-Barron Figari

2. DATE AND HOUR PRONOUNCED DEAD

March 20, 1967 12:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Reed Hall (Johns Hopkins Hospt.)
1620 McElderry Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1620 McElderry Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 16, 1940

9. AGE (in years
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student-Physician

10B. KIND OF BUSINESS OR INDUSTRY

Medical

11. BIRTHPLACE (State or foreign country)

Lima, Peru

12. CITIZEN OF
WHAT COUNTRY?

Peru

13. FATHER'S NAME

Renato Guzman-Barron

14. MOTHER'S MAIDEN NAME

Graciela Figari

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-56-5427

17. INFORMANT

ADDRESS

27 Johns Hopkins Hospt. Records-Balto.

18.

E976X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1620 McElderry Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 20 '67 A

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/20/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

3-22-67

23C. NAME of CEMETERY or CREMATORY

El Angel

23D. LOCATION (City, town, or county)

Lima

(State)

Peru

24A. DATE REC'D BY HEALTH DEPT.

MAR 21 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co.

ADDRESS

4905 York Rd.
Balto., Md.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67-2777BIRTH NO. 67 2777

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Mary Boyce

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1967 5:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

901 Ducatel Street

5. SEX

F.

6. RACE

C.7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)Sept.

8. DATE OF BIRTH

5-2-19309. AGE (In years
last birthday)36If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Housework

10B. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (State or foreign country)

MT. Olive N.C.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Bennie Smith

14. MOTHER'S MAIDEN NAME

Zettie Hill15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Clyde Smith 1623 Druid Hill

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Massive internal bleeding due to
stab wound of chest involving the
heart

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)house21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?1st. floor-hallway, 901 Ducatel St.21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)March 17 67 5:10 P.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 18, 196723A. BURIAL CREMATION,
REMOVAL (Specify)BURIAL

23B. DATE

3/25/67

23C. NAME of CEMETERY or CREMATORY

Hunterville House Prayer Cen.

23D. LOCATION (City, town, or county)

Hunterville

(State)

N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 21 1967MORTON DyeTT1701 LAURENS

WALCHER FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2778		CERTIFICATE OF DEATH		Registered No. 67 2778	
1. NAME OF DECEASED (Type or Print) Thomas Gray Wynn				2. DATE AND HOUR OF DEATH March 20, 1967 8:20 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-10 D. STREET ADDRESS (If rural, give location) 3808 Dolfield Avenue					
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2/2/97	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator			10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Newton Wynn			14. MOTHER'S MAIDEN NAME Lula Bell						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-10-0091		17. INFORMANT Mr. Henry Wright		ADDRESS 3808 Dolfield Ave		
18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Meningitis DUE TO Gram neg sepsis (B) pneumonia DUE TO Gram neg sepsis (C) Decubitus ulcer			INTERVAL BETWEEN ONSET AND DEATH 2 days 1 wk 1 mo.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus									
19A. DATE OF OPERATION 3/2/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 28 Feb 1967 to March 20 1967 , that (H) (we) last saw the deceased alive on 20 March 19 67 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Susan L. Howard MD				23B. DATE SIGNED March 20, 1967		23C. PHYSICIAN'S NAME (Type) M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23D. ADDRESS M.O.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert C. Taylor		25C. FUNERAL DIRECTOR Morton & Dyett F.H.		ADDRESS 1701 Laurens St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 67 2779

BIRTH NO. 67 2779		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) DAVID, WILLIAM		2. DATE AND HOUR OF DEATH 3/17/67 9:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALT C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT D. STREET ADDRESS (If rural, give location) 1151 N. MOUNT ST # 17	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/1/18
9. AGE (In years lost birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR	11. BIRTHPLACE (State or foreign country) S.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNK.	
14. MOTHER'S MAIDEN NAME CLARA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. UNK		17. INFORMANT PT.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL INFARCT ATHEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 5 days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/1/67 to 3/17/67 19 that (1) (we) lost the deceased alive on 3/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE H. Louden Krace		23B. DATE SIGNED 3/17/67	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-67	
24C. NAME of CEMETERY or CREMATORY Never Green Cem.		24D. LOCATION (City, town, or county) (State) Bennettsville S.C.	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Mortimer Dyer F.H.		25D. ADDRESS 1701 Laurens Street	

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1915

M-2613

67 2780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2780

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MC GRUDER, ERNEST G.

2. DATE AND HOUR OF DEATH

3/16/67

417
4-20

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3314 BRIGHTON STREET

5. SEX

M

6. RACE

C

7. (MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify))

8. DATE OF BIRTH

5-2-1886

9. AGE (In years
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Butcher

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

CARLETER, L. 3314 BRIGHTON STREET

18. 151X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) CANCER STOMACH WITH
DUE TO(B) SECONDARIES IN THE LIVER
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-21-1967 to 3-16-1967.
that (I) (we) last saw the deceased alive on 3-16-1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

V. Biswanath Pillai

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

3/16/67

23C. PHYSICIAN'S
NAME (Type)

V. BISWANATH PILLAI

M.D.

23D. ADDRESS

LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-18-67

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 21 1967

25B. NAME OF REGISTRAR

R. B. E. Taylor

25C. FUNERAL DIRECTOR

Randolph J. Collick

ADDRESS

2431 E. Oliver St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VIRGINIA

31-2

Primer - 1000

V. BIZWADZIGI, J. L. JONES

LUTHERAN BOARD OF CHRISTIAN RELATIONS

1
H-635

67 2781

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No 67 2781

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLEMENTINE HARDING

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1967

7:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

255 Ballou Court

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-8-41

9. AGE (In years
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Brown

14. MOTHER'S MAIDEN NAME

Elsie Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

Mrs Elsie A. Brown

ADDRESS

18.

795151

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXX~~

Cause of death undetermined

(autopsy and complete toxicological
findings insufficient to explain
death)

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-21-67

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 21 1967

24B. NAME OF REGISTRAR

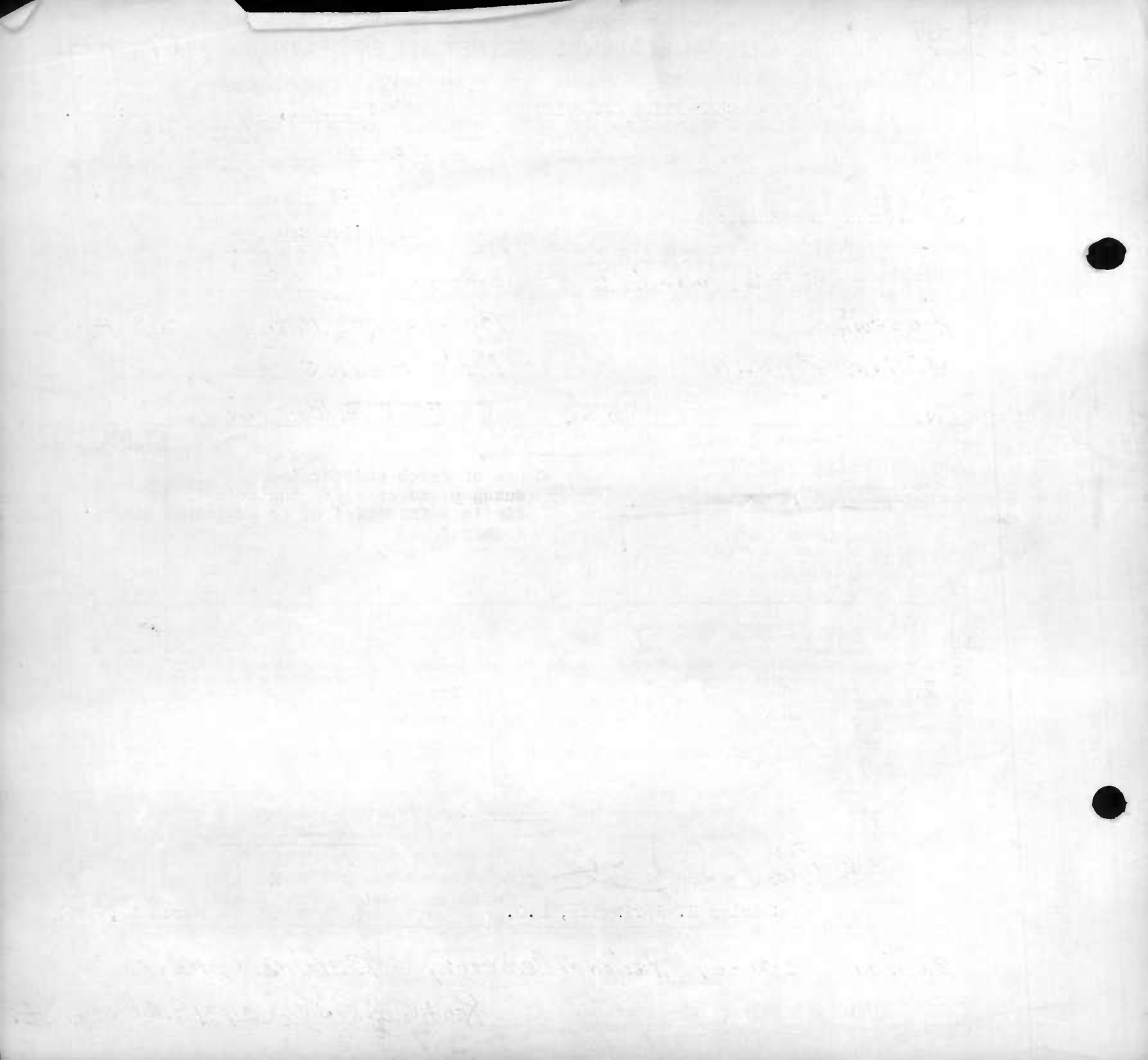
R. E. F. F. F.

24C. FUNERAL DIRECTOR

R. J. Collick

ADDRESS

2431 E. Oliver St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 2782	
BIRTH NO. 67 2782		CERTIFICATE OF DEATH								Registered No. 67 2782	
1. NAME OF DECEASED (Type or Print) SHERARD, HOLMES CECIL						2. DATE AND HOUR OF DEATH 15 MARCH 67 3:34 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY CECIL C. CITY OR TOWN (If outside city limits, write RURAL and give township) PORT DEPOSIT D. STREET ADDRESS (If rural, give location) ROLLING HILLS RANCH					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 04-11-30		9. AGE (In years last birthday) 36		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF-EMPLOYED				10B. KIND OF BUSINESS OR INDUSTRY TRAILER Sales				11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ANDREW C. SHERARD						14. MOTHER'S MAIDEN NAME FLOE CARPENTER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-32-1979		17. INFORMANT ROSEMARIE SHERARD, PORT DEPOSIT, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) Acute pneumonia and Pulmonary Edema.						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Hodgkins Disease Disfrase					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II						INTERVAL BETWEEN ONSET AND DEATH 11 1/2 hours					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 9 MARCH 19 67 to 15 MARCH 19 67 , that (H) (we) last saw the deceased alive on 15 MARCH 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.											
23A. SIGNATURE SIDNEY E. KIRKLEY <i>Sidney E. Kirkley</i>								M.D.		23B. DATE SIGNED 15 MARCH 67	
23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY.								23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 3-19-1967				24C. NAME OF CEMETERY or CREMATORY HOPE WEL CEMETERY			
24D. LOCATION (City, town, or county) (State) PORT DEPOSIT, MARYLAND.				25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967				25B. NAME OF REGISTRAR Robert E. Fisher			
25C. FUNERAL DIRECTOR Lee Q. Peterson & Son, Piquette, Md.				25D. ADDRESS							

Union Memorial Hosp

M W Married

Self-employed Trailer Sales

Andrew C. SHERMAN

FLOR CARPENTER

WIDOW

PORT DEPOSIT

Rolling Hills Ranch

DA-11-30 30

U.S.N.

YES

12 MARCH 67

Shirley E. Kibler

12 MARCH 67

12 MARCH 67

3-21-67 Andrew Sherman (County Port Deposit Maryland)
in the County of Cecil

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 2783		67 2783		P. M.	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BRUNO M. LIOI		March 20, 1967. 1:10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium			A. STATE Md. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214 27-02		
			D. STREET ADDRESS (If rural, give location) 4311 Arabia Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	February 5, 1891.	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Watchman		Penna. Railroad		Italy	USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Andrea Lioi			Teresa Sami		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		717-07-6797		Mrs. Rosaria Lioi (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.11-260X Mycardial Infarction			(A) DUE TO		2 yrs
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Diabetes Mellitus		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initialed medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-4 1966 to 3-19 1967, that (I) (we) last saw the deceased alive on 3-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Sebastian Russo M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				3/21/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SEBASTIAN RUSSO M.D.				5017 Harford Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/22/67.		Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 21 1967		Robert E. Farkas		Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2784	
BIRTH NO. 67 2784		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Loretta Harrison		2. DATE AND HOUR OF DEATH March 20, 1967 6²⁵ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Wesley Home, Inc. 2211 West Rogers Avenue		A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-15	
		D. STREET ADDRESS (If rural, give location) 2211 West Rogers Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 30, 1881	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Howard County, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles Reely		14. MOTHER'S MAIDEN NAME Henrietta Nicholson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-52-2938 J		17. INFORMANT ADDRESS The Wesley Home, Inc. same address	
18. 42214-191.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Squamous cell carcinoma face, right orbital region					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 15 December 1963 to 20 March 1967 , that (I) (we) lost saw the deceased alive on 17 March 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W Barnaby		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 21 Mar 67	
23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY		23D. ADDRESS 1531 E North Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/1967		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Barber		25C. FUNERAL DIRECTOR ADDRESS Wm. F. Tipton & Sons Baltimore, Md.	

Liberty Street, New York

June

James M. Smith, Jr.
The

11th Street, New York

2nd Floor

1231 E. 1st St.

John W. Smith
John W. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2785		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2785	
M.E. CASE NO. 67 2785				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Minnia A. Tantz			2. DATE AND HOUR OF DEATH March 20, 1967 5 AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 215 East 25th Street Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 215 East 25th Street 21218		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 22, 1872	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. John Hessey 1311 Fidelity Building		
18. 175.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinomatous ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Generalized Carcinomatous DUE TO (B) Carcinoma Artery DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 9 Months 2 Years
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-29-44 19 to 3-20-47 19, that (I) (we) last saw the deceased alive on 2-3-47 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. W. Peake				23B. DATE SIGNED 3-20-47	
23C. PHYSICIAN'S NAME (Type) E. W. PEAKE				23D. ADDRESS M.D. 4508 Harford Road Balto 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/1967		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1967		25B. NAME OF REGISTRAR Robert E. Tantz		25C. FUNERAL DIRECTOR Wm. J. Tantz Sons	
25D. ADDRESS Balto. Md.		25E. ADDRESS Wm. J. Tantz Sons			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2786		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2786	
M.E. CASE NO.		1. NAME OF DECEASED James W Lewis		2. DATE AND HOUR OF DEATH 16 March 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00624 N. Robinson St		A. STATE Maryland B. COUNTY Balto Co			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lansdowne 53-00			
		D. STREET ADDRESS (If rural, give location) 320 Fourth Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 2-22-87	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10B. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Lewis		14. MOTHER'S MAIDEN NAME Martha Ford	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217059991		17. INFORMANT Daniel F Lewis ADDRESS 21226 1417 Church St	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myxofibrosarcoma, retroperitoneal space		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 01-18-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Above		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1-9 1967 to 2-2 1967 , that (1) (we) last saw the deceased alive on 2-23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis A. Clark Jr		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-17-67	
23C. PHYSICIAN'S NAME (Type) FRANCIS A Clark Jr		23D. ADDRESS 11 E Chase St Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-67		24C. NAME OF CEMETERY or CREMATORY Louder Park	
24D. LOCATION (City, town, or county) (State) Balto Md					
25A. DATE REG'D BY HEALTH DEPT. MAR 22 1967		25B. NAME OF REGISTRAR Robert C. Galt		25C. FUNERAL DIRECTOR Butler Funeral Home ADDRESS 3631 Falls Rd	

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67 2787		BALTIMORE CITY HEALTH DEPARTMENT		67 2787	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		ANTHONY ALAKNA		2. DATE AND HOUR PRONOUNCED DEAD March 20, 1967 9:47 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		A. STATE Maryland B. COUNTY Baltimore 18-03 D. STREET ADDRESS (If rural, give location) 38 S. Fremont Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH 3/3/1892	9. AGE (In years last birthday) 75	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing Co.		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-9564		17. INFORMANT Anna V. Alakna - 418 E. Alexandria Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/23/67	
23C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.		23D. LOCATION (City, town, or county) (State) Baltimore, Md.		23E. DATE SIGNED 3/20/67	
24A. DATE REC'D BY HEALTH DEPT. MAR 22 1967		24B. NAME OF REGISTRAR P. D. E. Taylor		24C. FUNERAL DIRECTOR John J. Cowan & Son Inc.	
24D. ADDRESS 901 St. Hollins		24E. ADDRESS 23, Md. V			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2788</u>	
BIRTH NO. <u>67 2788</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WEBSTER L. SMITH Sr.</u>		2. DATE AND HOUR OF DEATH <u>3-18-67</u> <u>6:55 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home & Hospital</u> <u>35</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BAITIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>7-02</u> D. STREET ADDRESS (If rural, give location) <u>2522 E. Madison St. #5</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6-22-1903</u>	9. AGE (In years last birthday) <u>63</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jacob Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ida Chilcoat</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>273-01-1770</u>		17. INFORMANT <u>Mary Spapak Smith, wife, above</u> ADDRESS <u>Church</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Acute Degenerative</u> <u>hypertension</u> (B) DUE TO <u>Arteriosclerotic Heart Disease</u> (C) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-18</u> 19 <u>67</u> to <u>3-18</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-18-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. E. SUBONG, JR.</u>		23D. ADDRESS <u>Church Home & Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/22/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Mem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Dulaney Valley, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1967</u>			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>2601 E. Madison St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 2785	
BIRTH NO. 65-10637		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph Scott Norwicz</i>		2. DATE AND HOUR OF DEATH <i>March 17, 1967 2:15 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 26-02</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>4776 Ellison Ave</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>5-1-65</i>	9. AGE (In years lost birthday) <i>1 year</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Gerard Norwicz</i>			14. MOTHER'S MAIDEN NAME <i>Doris Neff</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Doris Neff Norwicz, mother, above</i>		
18. <i>754.5 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Congenital heart defect</i> (B) DUE TO <i>Status postoperative</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3-17-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Atrial septal defect</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-12</i> 19 <i>67</i> to <i>3-17</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>3-17</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carlos Boetsch</i>				23B. DATE SIGNED <i>3-17-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Carlos Boetsch</i>		23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/21/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Dulaney Valley Mem. Gardens</i>	
				24D. LOCATION (City, town, or county) (State) <i>Dulaney Valley, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Sadey</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Schimunek, Funeral Home, Inc. 3331 Brehms Lane</i>	



38-09-59 1B

V-32067 2780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 2780

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SOPHIA L. VITAK

2. DATE AND HOUR OF DEATH

MAR 17, 1967 10³⁰ P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31 BALTIMORE CITY HOSPITAL
4940 EASTERN AVE, BALTIMORE, MD.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE COUNTY

53-00

D. STREET ADDRESS (If rural, give location)

326 STEMMERS RUN RD

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

9-27-88

9. AGE (In years
last birthday)

78

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pickles

10B. KIND OF BUSINESS OR INDUSTRY

Helwig & Leitch

11. BIRTHPLACE (State or foreign country)

Baltimore
MARYLAND12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANK NICKEL

14. MOTHER'S MAIDEN NAME

FRANCES NICHOLAS CONRAD

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-20-8285

17. INFORMANT

ADDRESS

21224

RECORDS-BCH-4940 EASTERN AVENUE

18. 5-72-1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) CARDIO RESPIRATORY
DUE TO ARREST

5 MIN

(B) POSSIBLE PULM. EMBOLISM UNKNOWN
DUE TO(C) STATUS POST COLECTOMY 8 DAYS.
FOR BLEEDING DIVERTICULITIS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

3-9-1967

BLEEDING DIVERTICULITIS

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

BALT. CITY HOSPITAL

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-22-1967 19 67 to 3-17 19 67,
that (I) (we) last saw the deceased alive on 3-17 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3-17-67

23C. PHYSICIAN'S
NAME (Type)

DR. A. CHEN

M.D.

BCH-4940 EASTERN AVENUE, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/22/67

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cem.

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 23 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

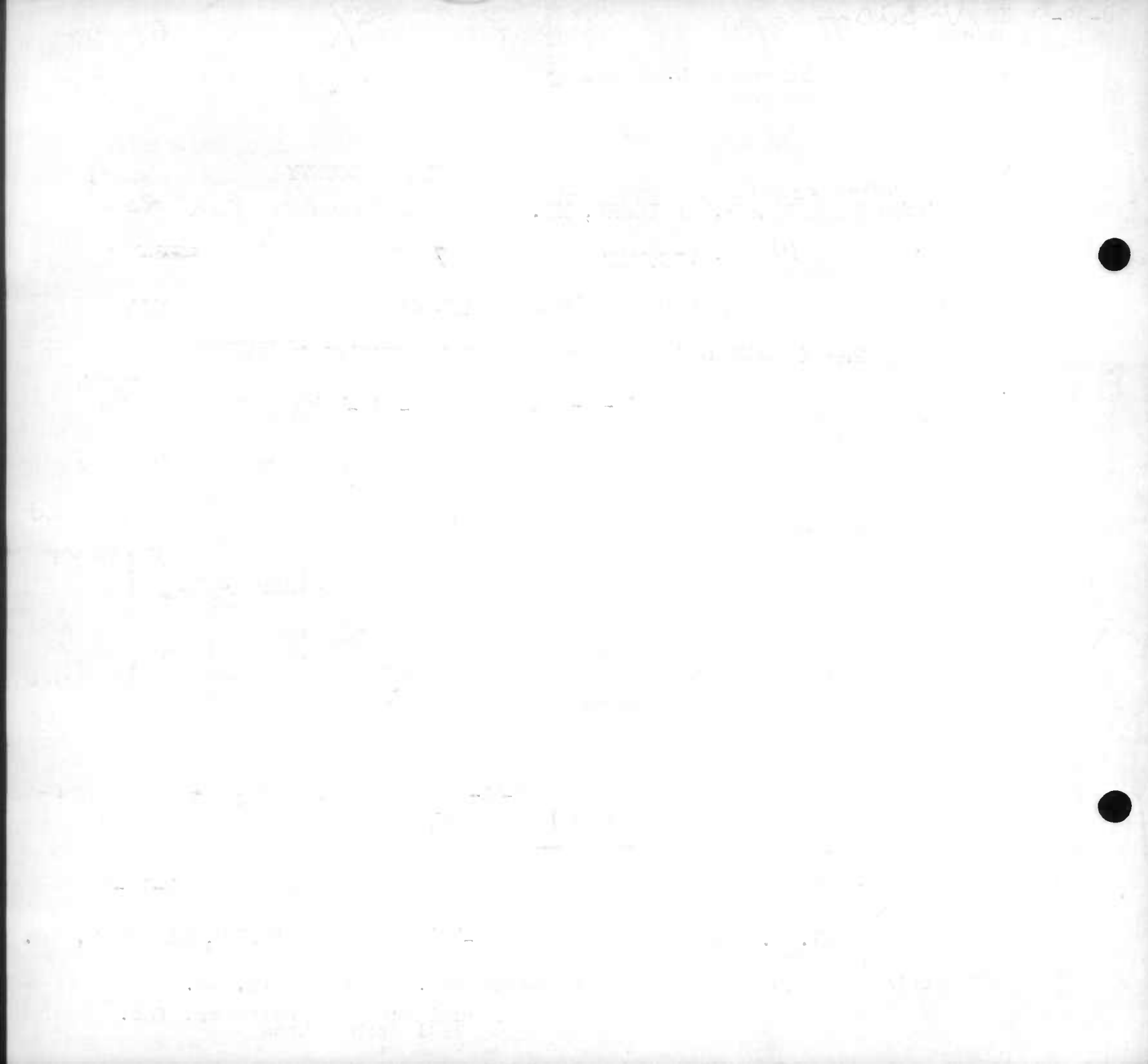
25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2791				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2791	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Commons, Spuro E.</i>				2. DATE AND HOUR OF DEATH <i>3/17 '11 930 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Mayland Guil House</i>				A. STATE <i>Md</i> B. COUNTY <i>Balto</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 201</i>			
				D. STREET ADDRESS (If rural, give location) <i>3201 Belair Road</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>10/14/99</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Stanley Commons</i>			14. MOTHER'S MAIDEN NAME <i>May Coronos</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>215 32942</i>		17. INFORMANT <i>Chart</i> ADDRESS		
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			(A) DUE TO <i>Coronary thrombosis</i>			<i>32 hours</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <i>Arteriosclerosis</i>				
			(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>T.U.R. for Benign prostatic enlargement</i>							
19A. DATE OF OPERATION <i>3/16/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>enlargement</i>		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/13 1967</i> to <i>3/17 1967</i> and that (I) (we) last saw the deceased alive on <i>3/17 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Daniel C. Wilkerson</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>3/17/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Daniel C. Wilkerson</i>		23D. ADDRESS <i>421 Regester Ave</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/20/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greek Orthodox Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR'S ADDRESS <i>Schimunek Funeral Home, Inc. 3331 Brehms Lane</i>			

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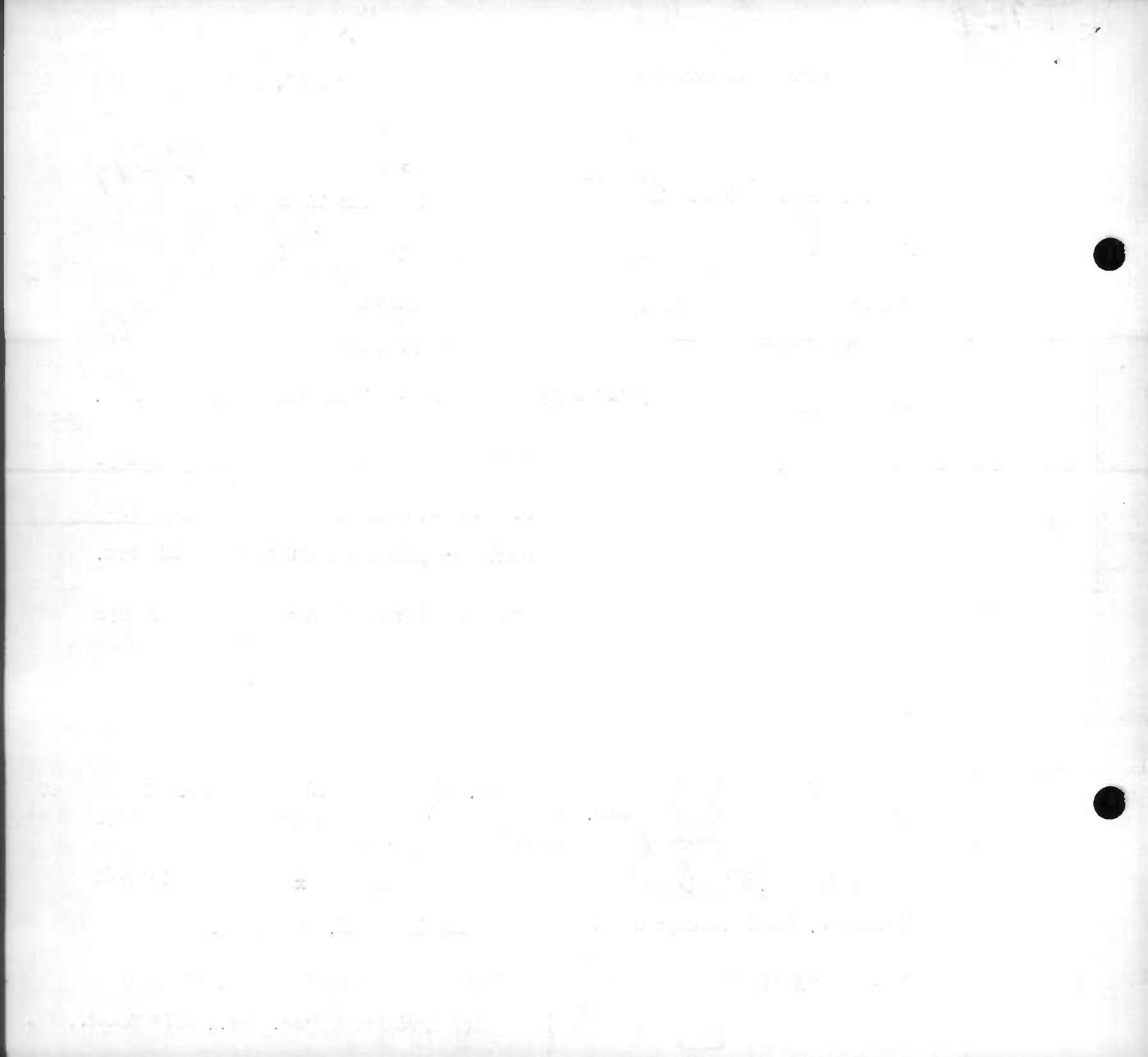
Handwritten text, possibly a date or reference number.

WALLACE COPIES

100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

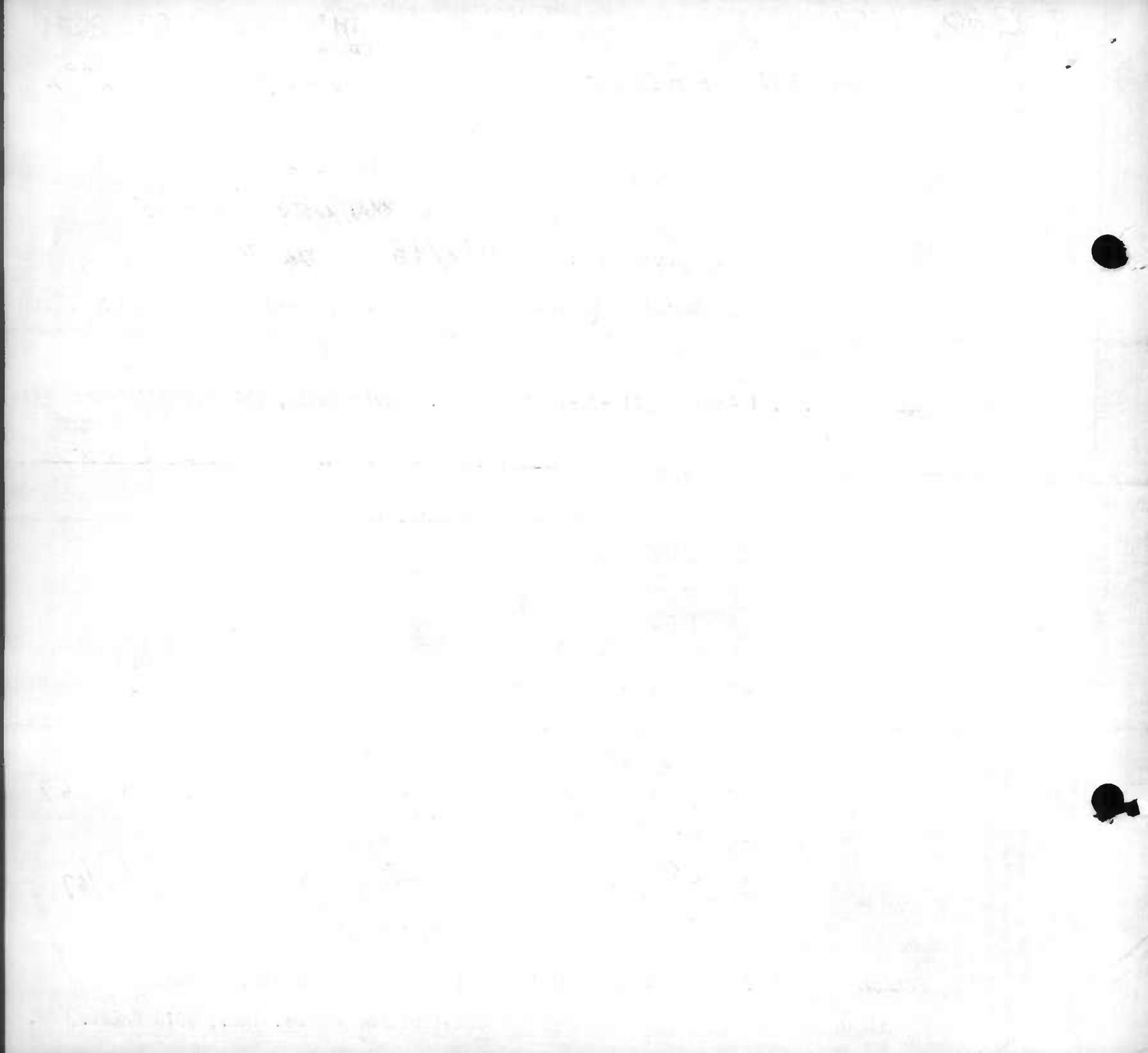
BALTIMORE CITY HEALTH DEPARTMENT									
67 2793					67 2793				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Susan Millicent Topor					March 20, 1967 7:58 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
US Public Health Service Hospital Wyman Pk. Drive & 31st St.					Michigan				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
V-19					Detroit 19211 Monte Vista St.				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
F		W		Single		9/19/43		23	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Teacher		School		Michigan			USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Louis Topor				Kathryn Pont					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				362-48-1449		Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
INTERVAL BETWEEN ONSET AND DEATH									
(A) Uremia 7 days									
(B) E. Coli septicemia 10 days									
(C) Acute promyelocytic leukemia 14 mos.									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
Congestive heart failure 4 days									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. WHILE AT WORK		21H. NOT WHILE AT WORK		21I. HOW DID INJURY OCCUR?	
21J. WHILE AT WORK		21K. NOT WHILE AT WORK		21L. HOW DID INJURY OCCUR?		21M. HOW DID INJURY OCCUR?		21N. HOW DID INJURY OCCUR?	
22. I certify that (I/this hospital) attended the deceased from Dec. 14, 1966 to Mar. 20, 1967, that (I/we) last saw the deceased alive on Mar. 20, 1967 and that in my/our opinion death occurred on the date and hour and from the causes stated above. (I/We) (did) (did not) view the body after death.									
23A. SIGNATURE								23B. DATE SIGNED	
Charles J. Lusch								3/20/67	
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS	
Charles J. Lusch, Surgeon (R)								US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial-Removal		3/21/67		Hebrew Memorial Park		Macomb County, Michigan			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 22 1967		Robert C. Lusch		Sol Levinson & Bros. Inc.		6010 Reist., Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>67 2794</u>	
BIRTH NO. <u>67 2794</u>		M.E. CASE NO. <u>(ABE FADER)</u>		CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>ALLEN FADER</u> <u>(ABRAHAM FADER)</u>						2. DATE AND HOUR OF DEATH <u>3-19-67</u> <u>6⁰⁰ A.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL Inc</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>97-16</u>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>					
						D. STREET ADDRESS (If rural, give location) <u>Pinkie Rd #15</u> <u>4516</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>		8. DATE OF BIRTH <u>11/6/195</u>		9. AGE (In years lost birthday) <u>71</u>		If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Municipal Employee</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Simon Fedder</u>				14. MOTHER'S MAIDEN NAME <u>Anna ?</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W. W. 1 Army</u>				16. SOCIAL SECURITY NO. <u>212-40-1484</u>		17. INFORMANT <u>Mr. Melvin Dubin, 904 Dropleaf Court #8</u>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRO VASCULAR ACCIDENT</u> DUE TO <u>ASCVD</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-12-67</u>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>3-12-197</u> to <u>3-19-1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 19 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>[Signature]</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>3/19/67</u>					
23C. PHYSICIAN'S NAME (Type) <u>Sinai Hospital</u>						23D. ADDRESS <u>Sinai Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/20/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Beth Jacob (Vecair)</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>				ADDRESS			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2795BIRTH NO. 67 2795

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)EDWINEDWARDJ.LOTES

2. DATE AND HOUR PRONOUNCED DEAD

March 20, 19674:35 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

4-5-67

5325 Hamlin Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5325 Hamlin Avenue

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)Married

8. DATE OF BIRTH

2/28/19169. AGE (In years
lost birthday)51If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Sheet Metal Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Sheet Metal

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.12. CITIZEN OF
WHAT COUNTRY?U.S.A.

13. FATHER'S NAME

Louis Lottes

14. MOTHER'S MAIDEN NAME

Anna R. Joh15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)No16. SOCIAL
SECURITY NO.212-07-5912

17. INFORMANT

ADDRESS

21215Mrs. Evelyn M. Lottes-5325 Hamlin Ave. Balt.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ostentio, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
3/20/67

23A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

3/23/67

23C. NAME of CEMETERY or CREMATORY

Druid Ridge

23D. LOCATION

(City, town, or county)

(State)

Pikesville 21208 Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 22 1967

24B. NAME OF REGISTRAR

Robert E. Finkema

24C. FUNERAL DIRECTOR

ADDRESS

Loring Byers-8748 Liberty Rd. Randallstown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2796	
<div style="display: flex; justify-content: space-between;"> Y-5210 67 2796 </div>					
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
META ELIZABETH YOUNG		3-17-1967		8:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
HOUSE IN THE PINES BEL AIR		MD			
90 5837 BELAIR RD		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTO. 27-44			
		D. STREET ADDRESS (If rural, give location)			
		5500 HILLTOP AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED	6-23-1886	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWORK		AT HOME		BALTO., MD	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Rudolph Schroeder		Anna B.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		213-14-845B		MRS. CORINNE COURTNEY	
				ADDRESS 1217 OAK PARK AVE, NERFOLK, VA.	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		1 week	
(This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)		Acute Congestive Heart Failure			
ANTECEDENT CAUSES		(B) DUE TO		1 week	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Myocardial Infarction			
		(C) Anteroselective Heart Disease			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from October 25, 1966 to March 12, 1967, that (I) last saw the deceased alive on MARCH 14, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Albert B. Bradley				3/18/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D. 4900 BELAIR RD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY	
BURIAL		3-20-67		IMMANUEL CEMETERY	
				24D. LOCATION (City, town, or county) (State)	
				BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 22 1967		Robert E. Johnson		J. Walter Conklin	
				ADDRESS 5444 BELAIR RD	

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 Oct 22 18
 Oct 23 18

3/18/10

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Wm B. Buckley

C-620

BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. <u>67 2797</u>									
BIRTH NO. <u>67 2797</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Ada F. Crouse</u>					2. DATE AND HOUR PRONOUNCED DEAD <u>March 17, 1967 6:10 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 University Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>Harford</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Edgewood 62-00</u>				
D. STREET ADDRESS (If rural, give location) <u>2002 Bayberry Road</u>									
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>May 30, 1898</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptometer Operator</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt - Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Fleetwood</u>					14. MOTHER'S MAIDEN NAME <u>Marian Brisco</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-03-2815</u>		17. INFORMANT <u>Claude T. Crouse, 2002 Bayberry Rd, Edgewood Md.</u>				
18. <u>E 900.16</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Cranio-cerebral injury</u>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>3/14/67</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>head-injuries</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>church</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Union Chapel Methodist Church 62-00</u>				
21D. TIME OF INJURY (APPROX.) <u>3 11 67 1:30 P.M.</u>			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fell down church steps</u>				
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Werner U. Spitz, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>3/18/67</u>			
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>			M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23B. DATE <u>Mar. 21, 1967</u>		23C. NAME of CEMETERY or CREMATORY <u>Trinity Lutheran Cemetery</u>		23D. LOCATION (City, town, or county) (State) <u>Joppa Harford Md.</u>			
24A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1967</u>			24B. NAME OF REGISTRAR <u>Robert E. Farber</u>		24C. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>				
ADDRESS									

N 8551.2670002805

[Faint, illegible text, possibly bleed-through from the reverse side of the page]

[Handwritten signature or initials]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 2798		67 2798	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Sheffield, Mr. Francis J.			3-20-67 11:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Bon Secours Hospital 34			Md. Balt Co.		
5. SEX M			6. RACE W		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
married			9-6-16		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
truck driver			food fair		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Henry Sheffield			Mary C. ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			15-01-3642		
17. INFORMANT			ADDRESS		
Angel M. Sheffield			2746 Augusta Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) MONOCYTIC LEUKEMIA		
ANTECEDENT CAUSES			(B) INTERNAL HEMORRHAGE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			TWO YEARS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from MARCH 20 1967 to MARCH 20 1967, that (I) (we) last saw the deceased alive on MARCH 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
S. W. Hoong				MARCH 21 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
500 WOONG, HONG				BEN SECOURS HOSPITAL BALTIMORE, MARYLAND 21223	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/24/67		Landon Park Cemetery	
25A. DATE RELEASED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 22 1967		Robert E. Parker, M.D.		Salvatore Capone, Sr., Inc. 901 Hallis St Balt. Md. 2123	

17 APRIL 20 11 41 AM '68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 2799				
BIRTH NO. 67 2799					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Clyde Wesley Snow					2. DATE AND HOUR OF DEATH March 18, 1967 11:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION 43 So. Balto. Gen. Hosp.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 1406 Battery Avenue				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-2-1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Work		10B. KIND OF BUSINESS OR INDUSTRY Lucas Bros.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edgar L. Snow					14. MOTHER'S MAIDEN NAME Virginia Kirby				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mae Snow				ADDRESS same as above
18. 430.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH immediate				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardio vascular disease (B) DUE TO					1 year				
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from January 19 1967 to March 18 1967 , that (I) (we) last saw the deceased alive on March 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Harry Deibel					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED March 20, 1967	
23C. PHYSICIAN'S NAME (Type) Harry Deibel M.D.					23D. ADDRESS 1226 S Hanover Street				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-1967		24C. NAME of CEMETERY or CREMATORY Louden Park Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE RECEIVED BY HEALTH DEPT. MAR 22 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS McCully, Funeral Home 130 E. Fort Ave. #30			

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67 2800

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2800

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2800		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) HARRY GUYER.		2. DATE AND HOUR OF DEATH March 20, 1967 7:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 925 S. Bouldin St. #21224	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12-12-32
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY --	9. AGE (In years last birthday) 33 34
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank E. Guyer		14. MOTHER'S MAIDEN NAME Ada Thelma Baker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 411-56-2754	17. INFORMANT ADDRESS BC# 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CENTRAL ANOXIA INTERVAL BETWEEN ONSET AND DEATH 48 hrs		CAUSE OF DEATH (A) DUE TO (B) PULMONARY TUBERCULOSIS (C) ASPIRATION PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH several months 48 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Renal shut down INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
19A. DATE OF OPERATION 3-19-67	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Anoxia	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-19-67 to 3-20-67, that (I) (we) last saw the deceased alive on 3-20-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John A. Burton		23B. DATE SIGNED 3-20-67	
23C. PHYSICIAN'S NAME (Type) John A. Burton		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE Mar. 23/67	24C. NAME of CEMETERY or CREMATORY Mt. Vista Cem.	24D. LOCATION (City, town, or county) (State) Johnson City Tenn.
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1967	25B. NAME OF REGISTRAR P. J. E. E. E.	25C. FUNERAL DIRECTOR Philip H. H. H.	ADDRESS 2024 Orleans St.



P-625 1 67 2801

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2801

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

PERKINS

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1967

12:25 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1309 Whatcoat Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1309 Whatcoat Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Jan. 15, 1907

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Food Store

11. BIRTHPLACE (State or foreign country)

S. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Perkins

14. MOTHER'S MAIDEN NAME

Ida Mathais

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-091677

17. INFORMANT

ADDRESS

Booker Perkins - 505 N. Carrollton

18. 241X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cor Pulmonale
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Bronchial Asthma.
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/16/6723A. BURIAL CREMATION
REMOVAL (Specify)

23B. DATE

3-20-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary A.C.

23D. LOCATION

(City, town, or county)

(State)

Cedar Hill Incl

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 22 1967

R. B. E. F. F. F.

Carrie V. Cooper - 512 N. Carrollton Ave
George L. R. R. 2222 N. Carrollton Ave

P-236

67 2802

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 2802

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK

PASTORE

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1967

10:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1147 E. Baltimore Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1147 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

JAN. 13 1916

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BARTENDER

10B. KIND OF BUSINESS OR INDUSTRY

BAR.

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN PASTORE

14. MOTHER'S MAIDEN NAME

MARY CICCARONI

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES

W.W.II

16. SOCIAL
SECURITY NO.

218-01-9610

17. INFORMANT

MR. JOHN PASTORE 3839 CHESTERFIED

ADDRESS

AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty Liver.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

MARCH 20/67 BALTO. NATIONAL

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

BALTO. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 22 1967

24B. NAME OF REGISTRAR

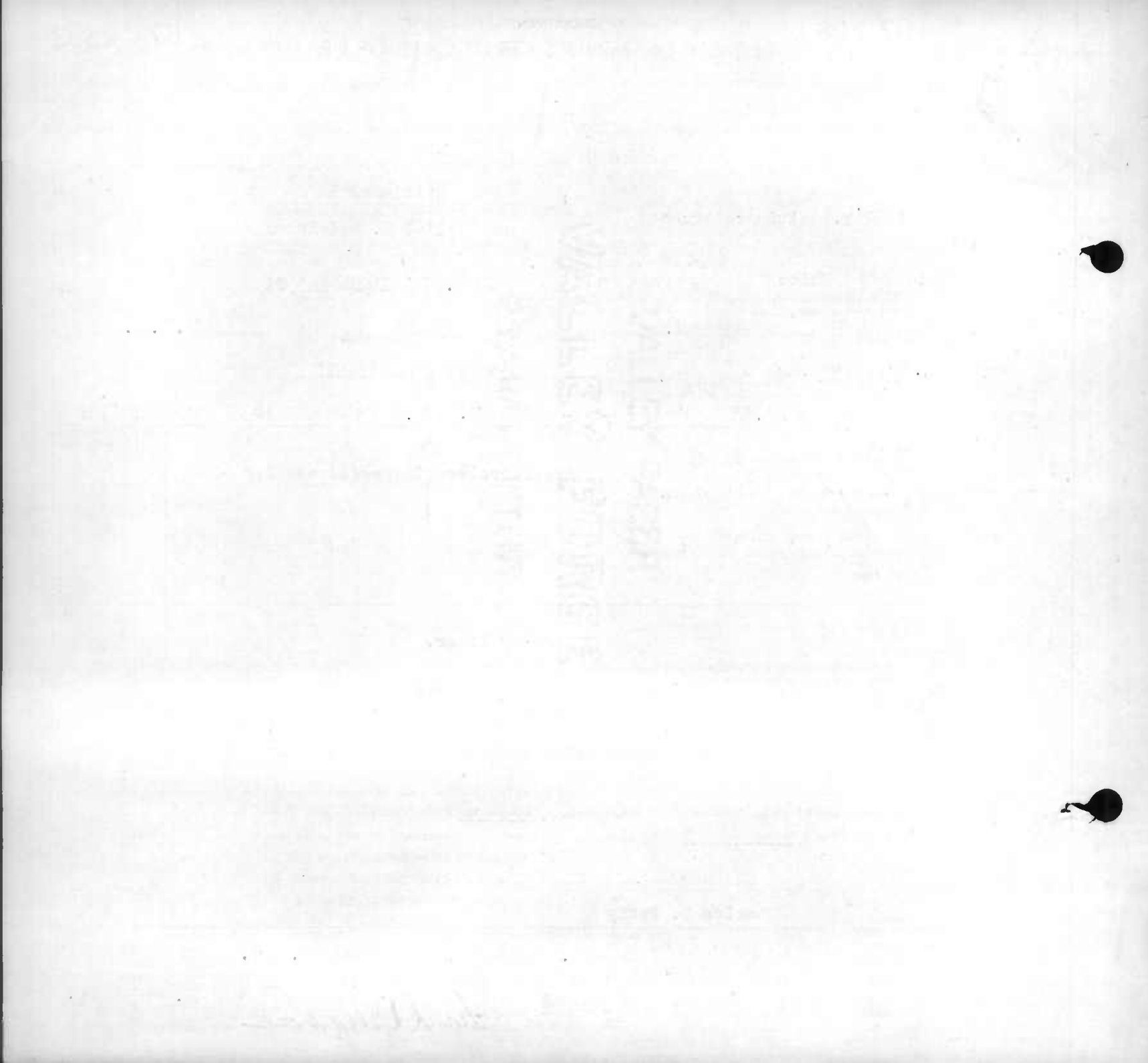
Robert E. Taylor

24C. FUNERAL DIRECTOR

Frank Della Vore

ADDRESS

322 S. HIGH ST.



1
W-300
W 300

67 2803 BALTIMORE CITY HEALTH DEPARTMENT 67 2803

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GRAFTON S. WHITE AKA White 2. DATE AND HOUR PRONOUNCED DEAD 3-14-67 2:20 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION SAM SMITH PARK - FOOT OF CALVERT ST. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-01

Police Boat Gaither - Sgt. John Younger D. STREET ADDRESS (If rural, give location) 930 Carrollton Avenue - North 21217

5. SEX Male 6. RACE Colored 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH 9. AGE (In years last birthday) 42 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. E 929.9 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Drowning, presumed (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown 00-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Unknown 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE WORK Unknown 21F. HOW DID INJURY OCCUR? Unknown

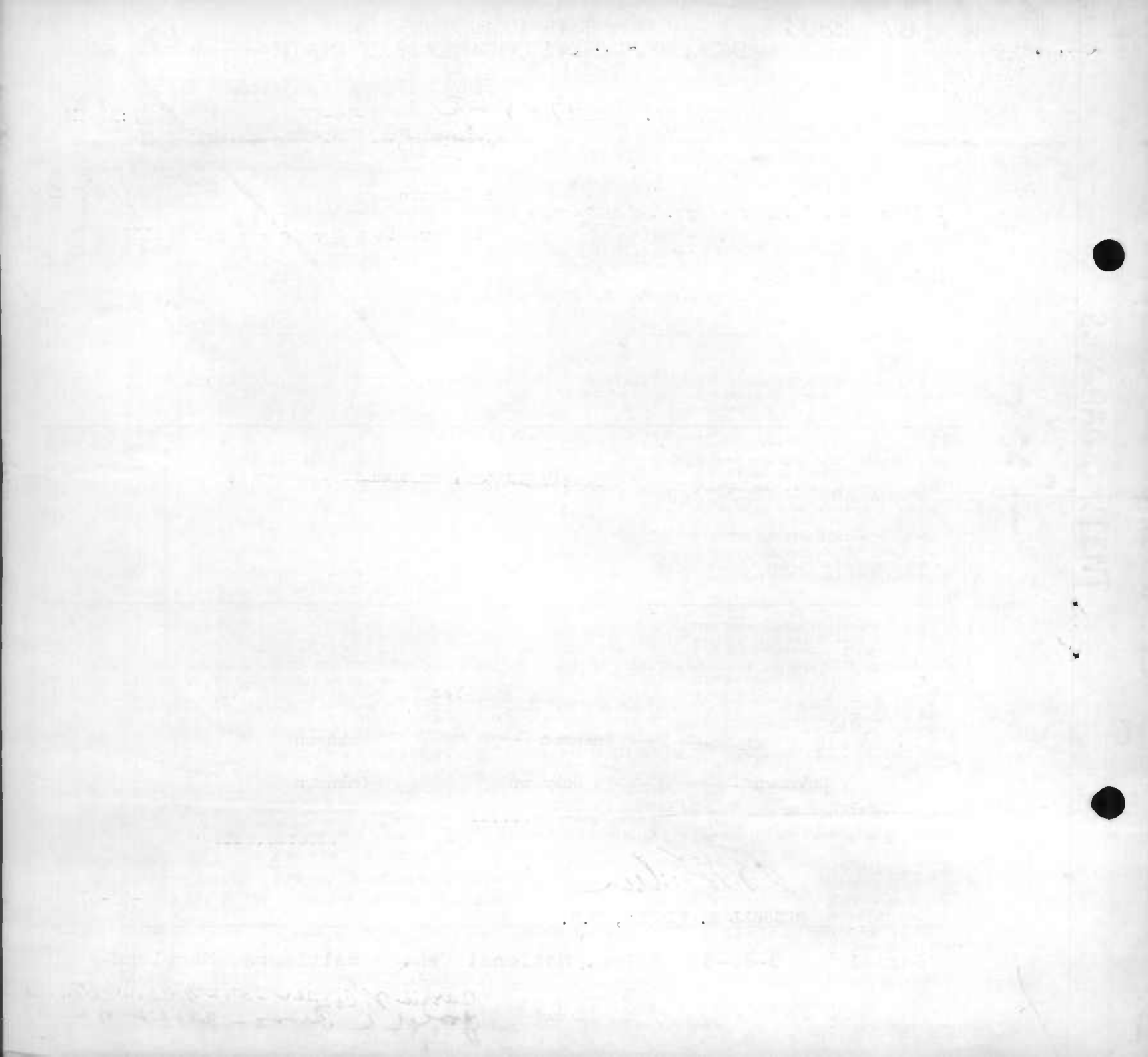
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 3-15-67

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 3-20-67 23C. NAME of CEMETERY or CREMATORY Balto. National Cem. 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. MAR 22 1967 24B. NAME OF REGISTRAR Robert E. Fisher 24C. FUNERAL DIRECTOR Carrie V. Cooper - 512 N. Carrollton Ave 24D. ADDRESS 2222 W. N. 2

VS 151-REV. 1/1/65 N 990X



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2804		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2804	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) David Daniel Green		2. DATE AND HOUR OF DEATH 3/20/67 6:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-07 		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital 		D. STREET ADDRESS (If rural, give location) 2927 Winchester St. 		E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 	
5. SEX M 	6. RACE C 	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married 	8. DATE OF BIRTH 7/8/03 	9. AGE (In years last birthday) 63 	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor 		10B. KIND OF BUSINESS OR INDUSTRY Foundry 		11. BIRTHPLACE (State or foreign country) South Carolina 	
13. FATHER'S NAME Maje Green 		14. MOTHER'S MAIDEN NAME Marilla Fitz 		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 27-01-537 		17. INFORMANT Mrs Lillian Green 		ADDRESS 2927 Winchester St. 	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Edema 24 hrs. 		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if giving rise to the above cause (A) stating UNDERLYING CONDITION last. Digitalis Intoxication Weeks 		20. CAUSE OF DEATH (A) DUE TO Arteriosclerotic cardiovascular disease 	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 		23. MEDICAL CERTIFICATION II 	
19A. DATE OF OPERATION 0 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/20 19 67 to 3/20 19 67 , that (2) (we) last saw the deceased alive on 3/20 19 67 and that (3) (our) opinion on death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard du Bay 		23B. DATE SIGNED 3/20/67 		23C. PHYSICIAN'S NAME (Type) Bernard du Bay M.D. 	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 		24B. DATE 3-25-67 		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park 	
24D. LOCATION (City, town, or county) (State) Arbutus Md. 		25A. DATE REC'D BY HEALTH DEPT. MAR 22 1967 		25B. NAME OF REGISTRAR Robert E. Jenkins 	
25C. FUNERAL DIRECTOR Mortone Dyett F.H. 		25D. ADDRESS 1701 Laurens St. 		25E. ADDRESS 1701 Laurens St. 	

H. 610

67 2805

BALTIMORE CITY HEALTH DEPARTMENT

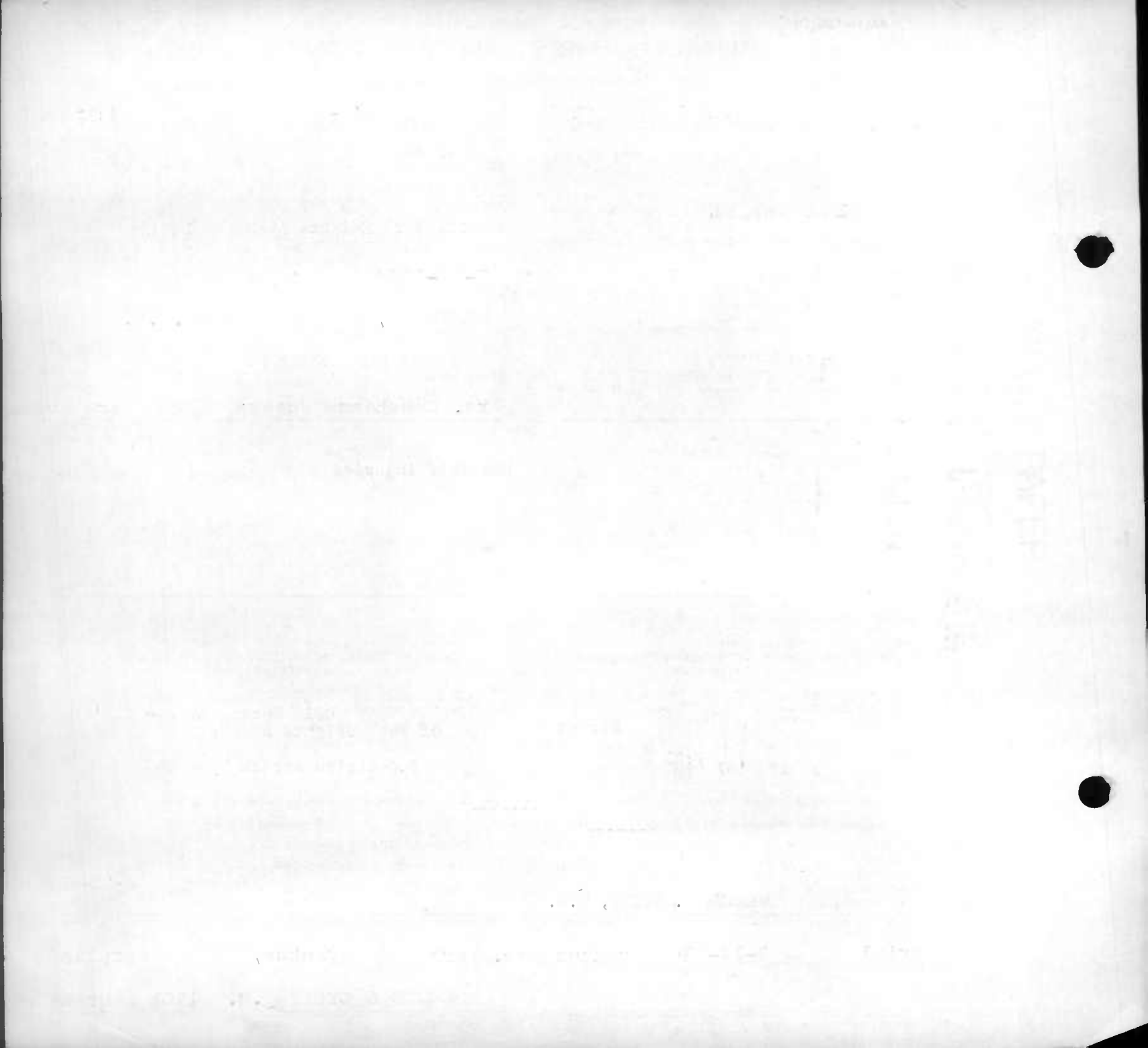
67 2805 ✓

BIRTH NO. 64-25117

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
HARVEY KIRK				3-20-67 6:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				A. STATE Maryland			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13			
				D. STREET ADDRESS (If rural, give location) 4331 Park Heights Avenue 21215			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD		8. DATE OF BIRTH 7-24-1964		9. AGE (In years last birthday) 2 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HARVEY				14. MOTHER'S MAIDEN NAME CONSTANCE SPEAKS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Constance Speaks		ADDRESS 2006 Park Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Cold Spring Lane - 203' East of Park Heights Avenue 27-16			
21D. TIME OF INJURY (APPROX.) 3 19 '67 7:25 PM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by auto			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-21-67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-24-67		23C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		23D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
24A. DATE REC'D BY HEALTH DEPT. MAR 22 1967		24B. NAME OF REGISTRAR Robert E. Jackson, M.D.		24C. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																	
BIRTH NO. 67 2806					CERTIFICATE OF DEATH					Registered No. 67 2806							
1. NAME OF DECEASED (Type or Print) Burnis, Elizabeth (Eliza)										2. DATE AND HOUR OF DEATH 3/20/67 12³⁵ P M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 15-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1331 Stockton Street							
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 4/01/98		9. AGE (In years lost birthday) 68		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Balt. Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Solomon Crosby					14. MOTHER'S MAIDEN NAME Emma Crosby												
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Joseph Barney					ADDRESS 416 Mt. Holly Street					
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD										(A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 2 hrs. yes.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																	
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 3/17 19 67 to 3/20 19 67 , that (I) (we) last saw the deceased alive on 3/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																	
23A. SIGNATURE C. H. Brown, III					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 3/20/67							
23C. PHYSICIAN'S NAME (Type) C. H. Brown, III					23D. ADDRESS The Johns Hopkins Hospital												
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 3-24-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery			24D. LOCATION (City, town, or county) (State) Balto. Md.									
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR MORTON + Dye IT			ADDRESS 1701 LAURENS								



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2807		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2807	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LINK - O.C.		2. DATE AND HOUR OF DEATH 3/21/67 5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND General Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where Deceased Aved. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-01 D. STREET ADDRESS (If rural: give location) 4920 Belair Rd.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/24/17	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME ROBERT C. LINK			14. MOTHER'S MARDEN NAME Elsie Caldwell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-09-5617		17. INFORMANT ADDRESS admission record	
18. 540.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pneum. Attraction 2° Pneumonia DUE TO (B) Pneumonia 2° Arteriosclerotic heart DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5d 5d	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3/14/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gastric ulcer		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) never		21E. INJURY OCCURRED While <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from 3/13 1967 to 3/21 1967 , that (I) we last saw the deceased alive on 3/21 1967 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.					
23A. SIGNATURE Fred R. Eilber M.D.				23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type) Fred R. Eilber		23D. ADDRESS MARYLAND General			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/67		24C. NAME OF CEMETERY or CREMATORY The End of The Trail Cemetery	
24D. LOCATION (City, town, or county) (State) East Rainelle, West Virginia		25A. DATE REC'D BY HEALTH DEPT. MAR 24 1967			
25B. NAME OF REGISTRAR Robert C. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214			

20

5/12/15

2015-05-12

Ward and General
Hospital

Ward and General
Hospital
4200 Bell St

Ward and General
Hospital
Robert E. Link

Ward and General
Hospital
4200 Bell St

5200-05-12

Ward and General

5/12/15

Ward and General

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Ward and General
Hospital

Ward and General
Hospital

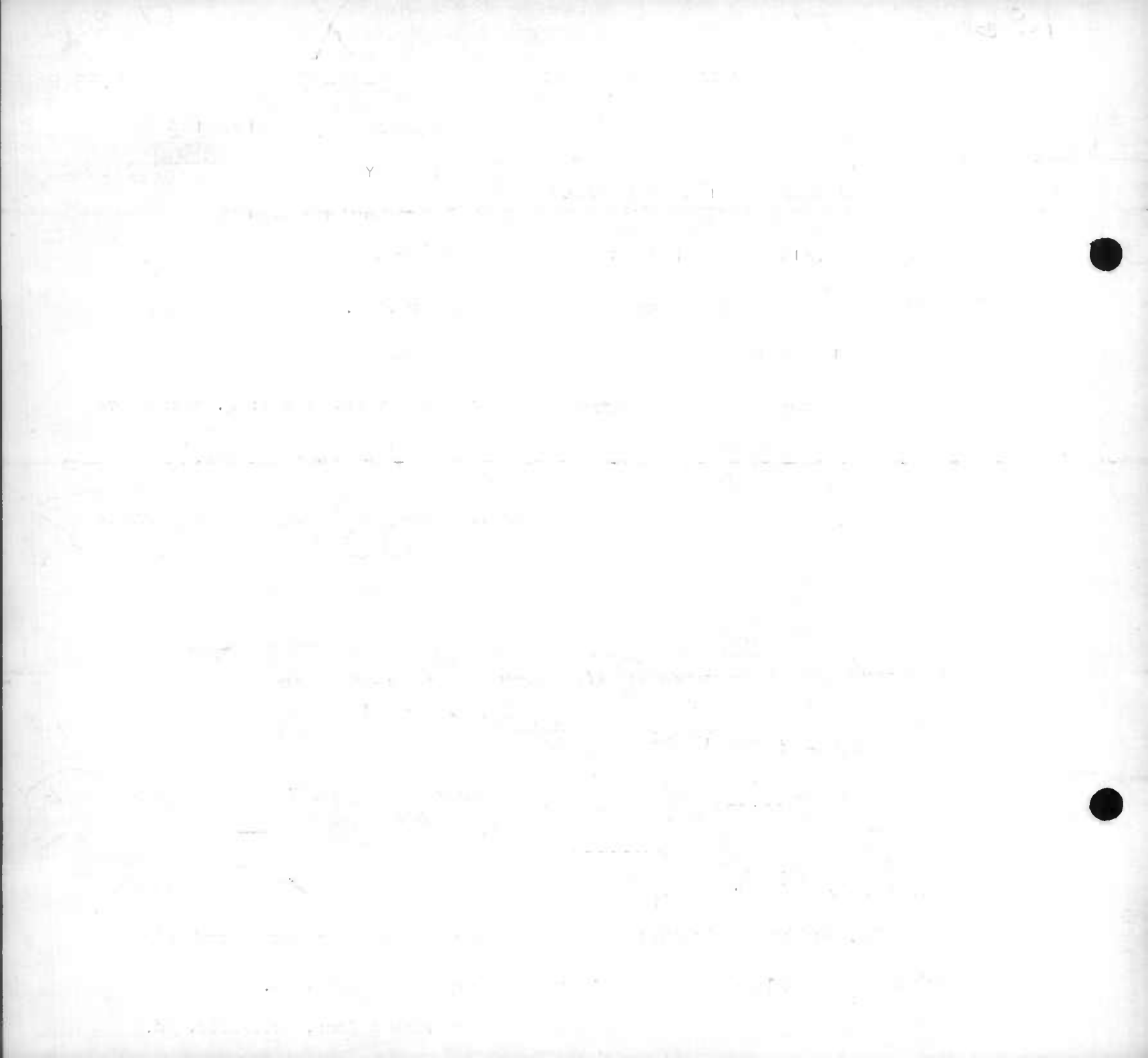
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2808		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2808	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LIBERATA CALVANO		2. DATE AND HOUR OF DEATH 3/19/67 - 2:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md. B. COUNTY BALTO.			
House in the Pines BELVEDERE AVE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. Md.		27-18	
D. STREET ADDRESS 5123 ARBUTUS AVE.					
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOW	8. DATE OF BIRTH DEC. 26 1881	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY RES.		11. BIRTHPLACE (State or foreign country) ITALY.	
12. CITIZEN OF WHAT COUNTRY? ITALY		13. FATHER'S NAME MATTHEW DI LIELLO		14. MOTHER'S MAIDEN NAME MARGARITE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-01-8760		17. INFORMANT ADDRESS MRS GRACE CUNEO 5123 ARBUTUS AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Myocardial Infarction			
ANTECEDENT CAUSES		(B) Coronary Artery Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/1961 to 3/1967, that (I) (we) last saw the deceased alive on 3/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Wilson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/19/67	
23C. PHYSICIAN'S NAME (Type) DANIEL WILSON		23D. ADDRESS 5721 Park Hyatt Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/22/67		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION BALTO. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1967		25B. NAME OF REGISTRAR R. L. E. Taylor		25C. FUNERAL DIRECTOR Frank Della Vigna	
25D. ADDRESS 222 S. HIGH ST					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No.	
BIRTH NO. 67 2809		M.E. CASE NO.		67 2809	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LEE ALLEN EVANS			3-15-67 3:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
33 THE JOHNS HOPKINS HOSPITAL			MARYLAND WICOMICO		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			SALISBURY 72-12		
			D. STREET ADDRESS (If rural, give location)		
			115 COULBOURNE DRIVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
MALE	WHITE	INFANT	02-05-67		1 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
None		None	Salisbury, Md.		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
FRANKLIN EVANS			Joyce Gano		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		None	Franklin Evans, Same as 4. abcd above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
754.51			Congenital Heart Disease		1 mo
ANTECEDENT CAUSES			Branching of pulmonary artery		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
3/14	Congenital Heart Disease	Yes	No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 3/14 19 67 to 3/15 19 67 that (I) (we) last saw the deceased alive on 3:25 3/15 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. Walter Smithwick, III			3/15		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. Walter Smithwick			The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	3/18/67	Ewell Church Cemetery	Ewell, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
MAR 22 1967	R. E. E. Taylor	Bradshaw & Sons, Crisfield, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

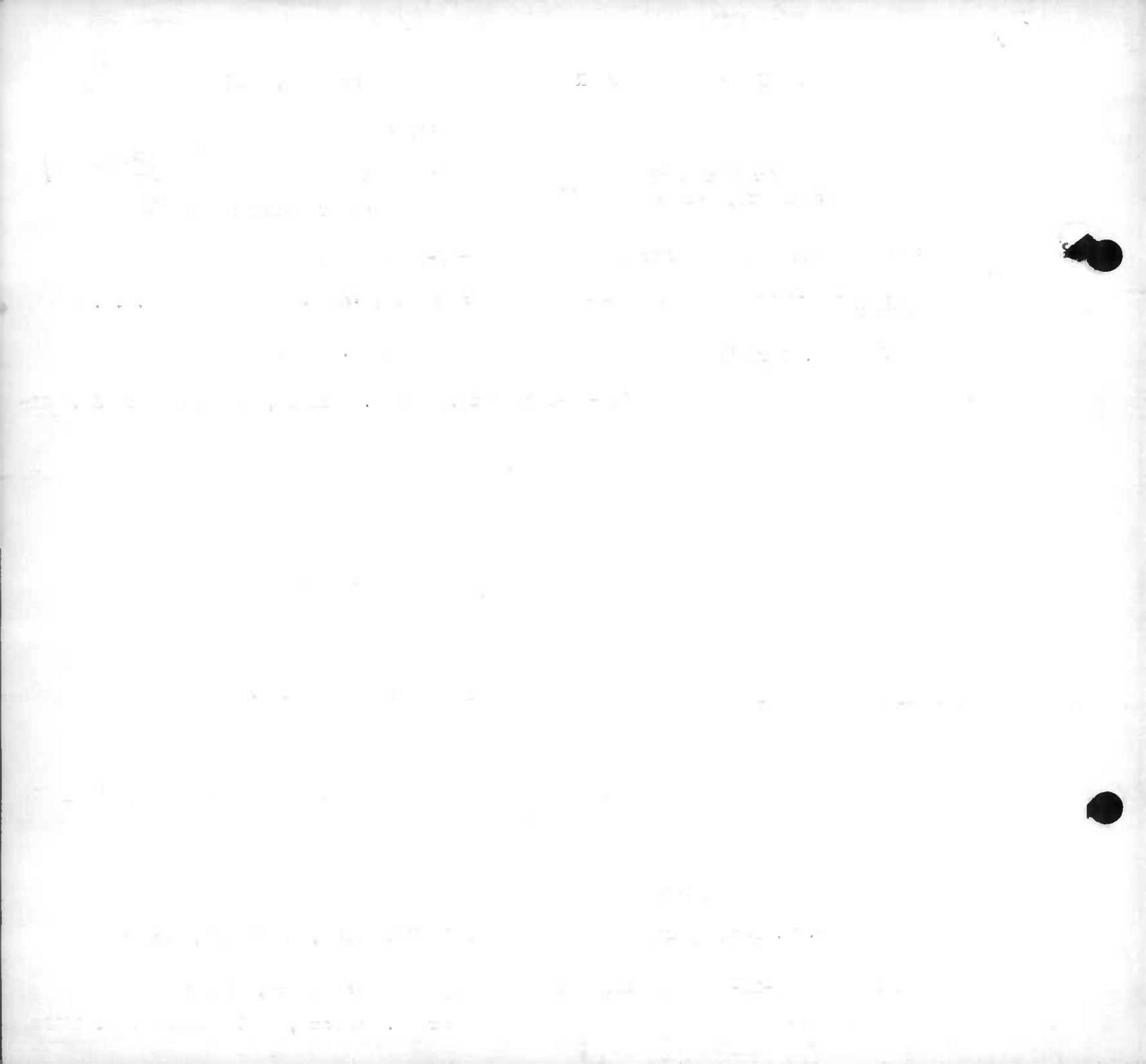
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2810		REGISTERED NO. 67 2810	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) William E. Barbour Sr.				2. DATE AND HOUR OF DEATH 3-20-1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6403 Falkirk Road 21212				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6403 Falkirk Road 21212			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-12-1892		9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10B. KIND OF BUSINESS OR INDUSTRY Black & Decker		11. BIRTHPLACE (State or foreign country) Baltimore City Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry L. Barbour				14. MOTHER'S MAIDEN NAME Nellie Sapp			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-3374A		17. INFORMANT ADDRESS Mrs Catherine Barbour 6803 Falkirk Rd			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Carcinomatosis Primary Tumor (B) DUE TO probably tail of pancreas (C) ASCD, diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 1965 to March 1967 , that (I) (we) last saw the deceased alive on 3/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE J. Brown, M.D.				23B. DATE SIGNED 3/20/67		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-22-1967		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore,				24E. (State) Md		25A. DATE REC'D BY HEALTH DEPT. MAR 22 1967	
25B. NAME OF REGISTRAR R. E. F. F. F.				25C. FUNERAL DIRECTOR ADDRESS 7401 Belair Road			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 2811	
BIRTH NO. 67 2811				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) JONES, Albert Cosby				2. DATE AND HOUR OF DEATH March 19, 1967 8:15 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				District of Columbia			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington			
				D. STREET ADDRESS (If rural, give location) 3640 Minnesota Ave., SE			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-25-99	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10B. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John D. Jones				14. MOTHER'S MAIDEN NAME Nannie McClelland			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-25-42 to 3-10-43		16. SOCIAL SECURITY NO. 579-14-0453		17. INFORMANT Records		ADDRESS V. A. Hospital, Baltimore, Md. 21218	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Massive dilatation of stomach DUE TO resection of Carcinoma of Esophagus (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
19A. DATE OF OPERATION 3-7-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Esophagus		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from February 23, 1967 to March 19, 1967, that (X) (we) last saw the deceased alive on March 19, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Crile Crisler</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 20, 1967	
23C. PHYSICIAN'S NAME (Type) CRILE CRISLER				23D. ADDRESS M.D. V. A. Hospital, Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-24-1967		24C. NAME of CEMETERY or CREMATORY ALEXANDRIA NAT.		24D. LOCATION (City, town, or county) (State) ALEXANDRIA, VA.	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 22 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR W. ERNEST JARVIS CO. 1432 YOU STREET N.W.			

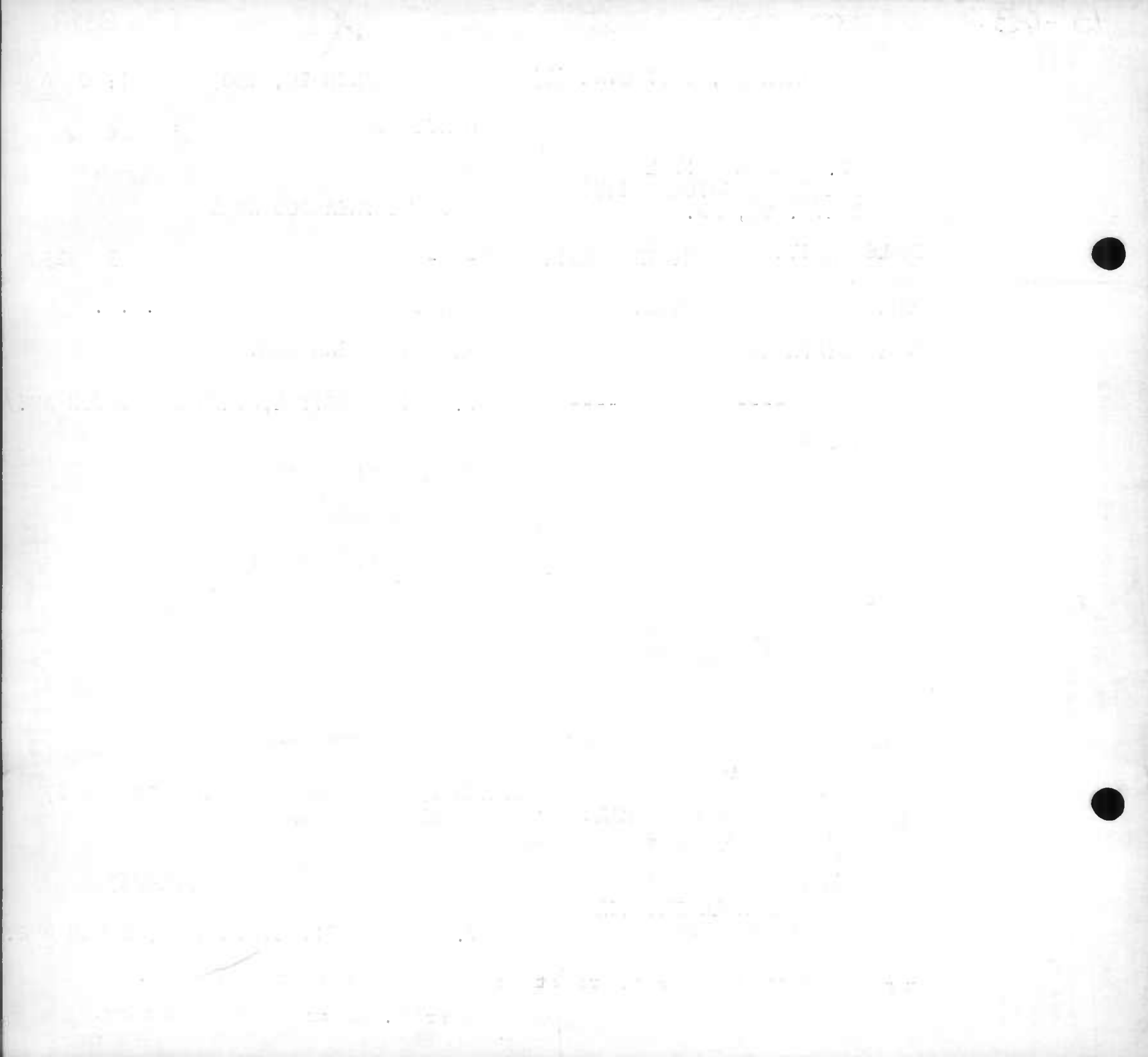




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

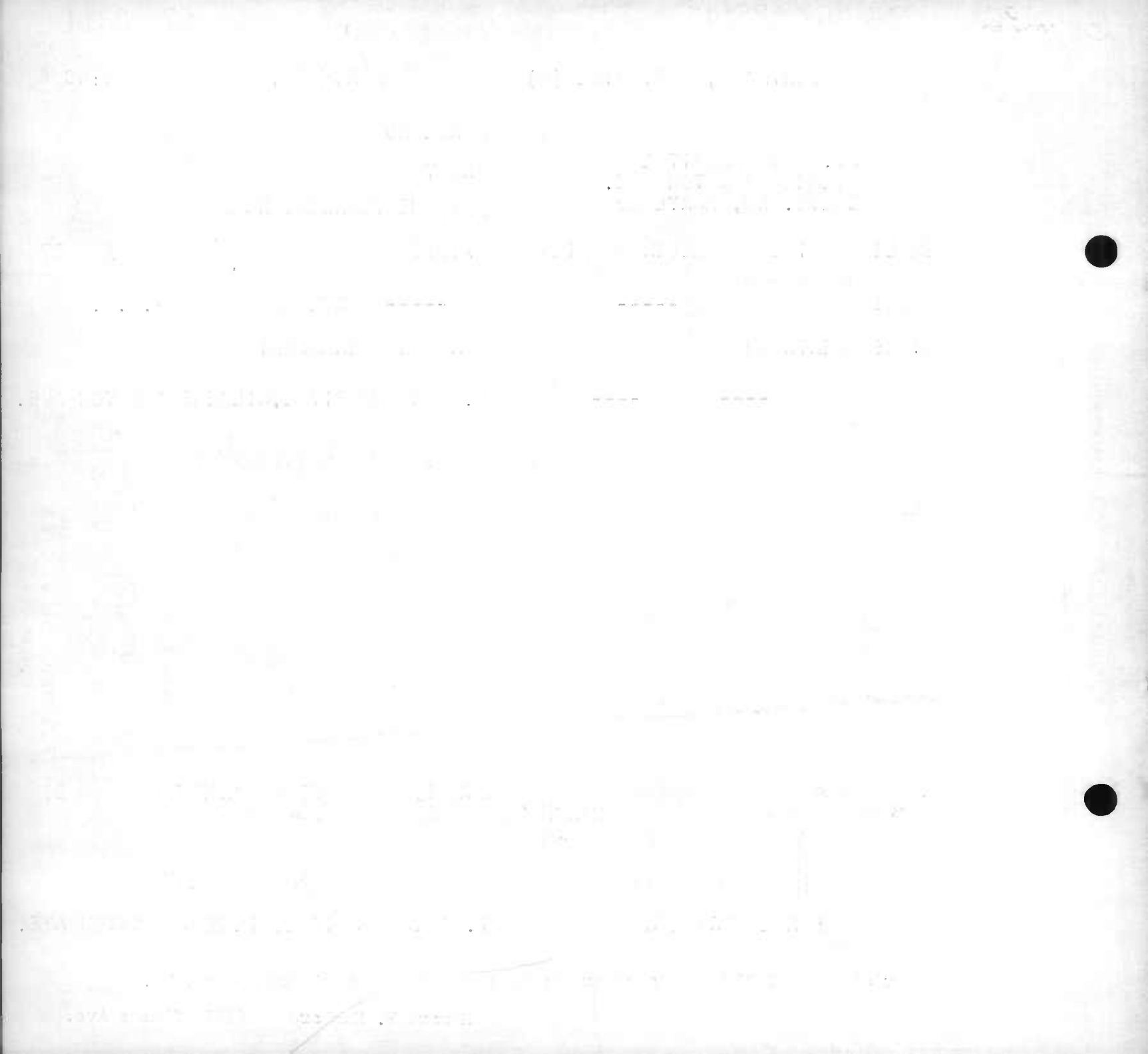
BIRTH NO. 47-05714 67 2813		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2813	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		BERTRAND, BABY GIRL (B)		MARCH 20, 1967 1:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD.			MARYLAND		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
ARBUTUS			5517 HEATHERWOOD ROAD		
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
FEMALE		WHITE		NEVER MARRIED	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	
3-19-67		3		25	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
MARYLAND		U.S.A.		JAMES BERTRAND	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
FRANCES BERKOUSKI		NO		----	
17. INFORMANT		ADDRESS			
ST. AGNES HOSPITAL, WILKENS & CATON AVE		ST. AGNES HOSPITAL, WILKENS & CATON AVE			
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) DUE TO		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Cardiac & respiratory insufficiency		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Immature brain stem		
II			(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Prematurity (23 weeks)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from		MARCH 19 19 67		to MARCH 20 19 67	
that (2) (we) lost saw the deceased alive on		MARCH 20 19 67		and that in (3) (our) opinion death occurred on the date	
and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
HAROLD BRENNER		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		3/20/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
HAROLD BRENNER		ST. AGNES HOSPITAL, WILKENS & CATON AVE.		Burial	
24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
3/22/67		Baltimore National		Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 22 1967		Robert E. Taylor		Howard H. Hubbard	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	
4107 Wilkens Ave.		4107 Wilkens Ave.		4107 Wilkens Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

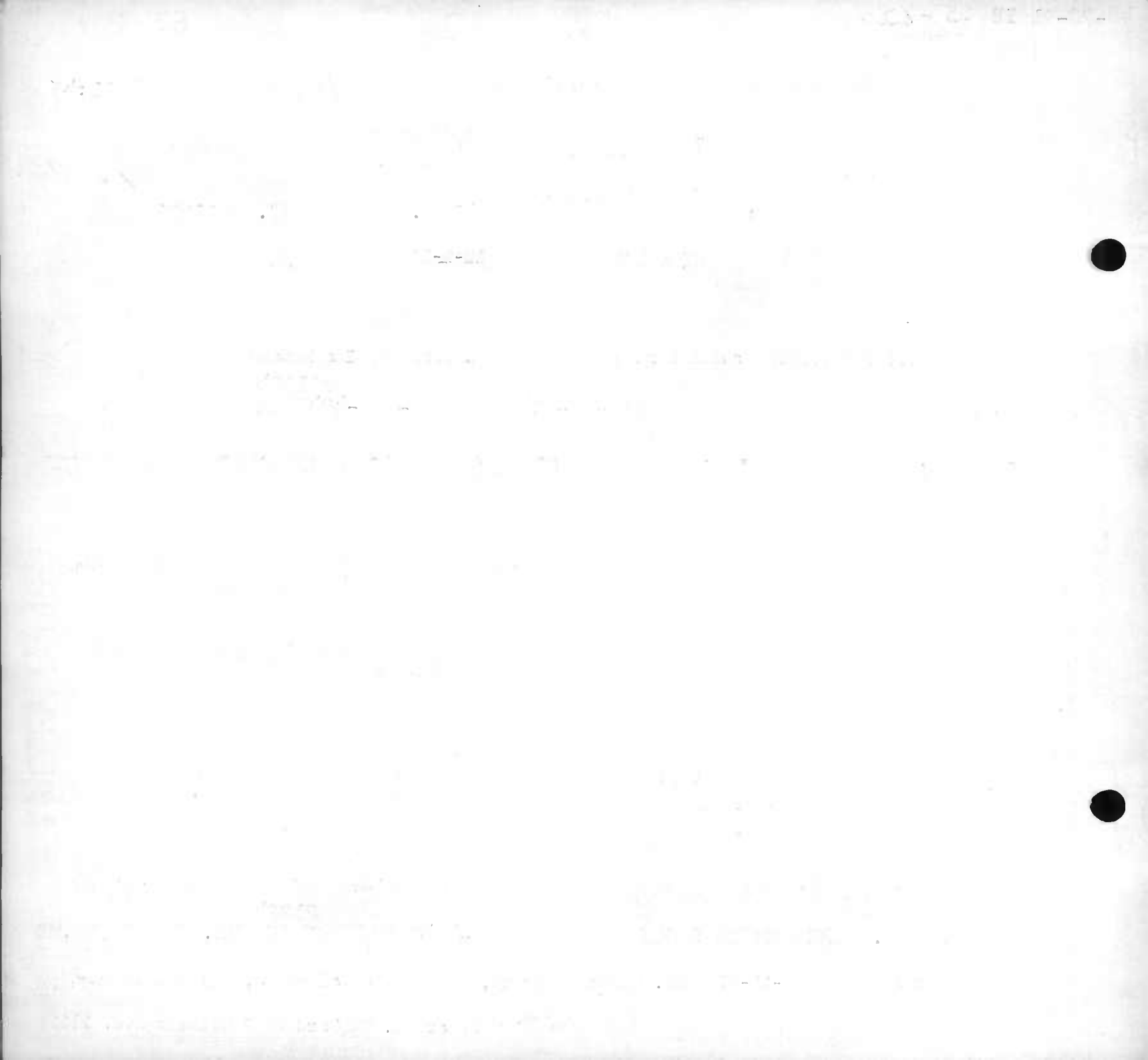
BIRTH NO. 67-63814		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2814	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		BERTRAND, BABY GIRL (A)		2. DATE AND HOUR OF DEATH MARCH 20, 1967 1:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTO. 29, MARYLAND		A. STATE MARYLAND		B. COUNTY Balt. Co.	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		ARBUTUS 53-00	
		D. STREET ADDRESS (If rural, give location)		5517 HEATHERWOOD ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED NEVER MARRIED	8. DATE OF BIRTH 3/19/67	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 3 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE		-----		----- MARYLAND	
13. FATHER'S NAME JAMES BERTRAND			14. MOTHER'S MAIDEN NAME FRANCES BERKOUSKI		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		-----		ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Cardiac & respiratory insufficiency			
		(B) DUE TO Immature brain stem			
		(C) DUE TO Prematurity (23 weeks)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from MARCH 19 19 67 to MARCH 20 19 67, that (we) last saw the deceased alive on MARCH 20 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold Brenner				23B. DATE SIGNED 3/20/67	
23C. PHYSICIAN'S NAME (Type) HAROLD BRENNER				23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/67		24C. NAME of CEMETERY or CREMATORY Baltimore National	
				24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 2815		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2815	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		MOLLIE M. SUBOCK		3/19/67 11:49 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
BALTIMORE CITY HOSPITALS		MARYLAND			
31 4940 EASTERN AVENUE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
BALTIMORE, MARYLAND #21224		D. STREET ADDRESS (If rural, give location)		943 W. LOMBARD ST. #21223	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	WHITE	WIDOWED, DIVORCED (specify)	10-9-1886	XX 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
			MARYLAND	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
DANIEL DOZZEN			IDA McCABE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
		216-12-7149	#21224		4940 EASTERN AVENUE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) POSSIBLE acute pulm. embolus		minutes	
ANTECEDENT CAUSES		(B) CVA, ASCVD		weeks	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Carcinoma of the colon		months	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 3/15 1967 to 3/19 1967, that (I) (we) lost saw the deceased alive on 3/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Terry Erisel Gagon M.D.				3/19/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. TERRY ERSEL GAGON		21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	3-22-67	Mt. Olive Cemetery,		Randallstown, Balto. County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 22 1967		Robert E. Farber		ADDRESS	
				Howard H. Hubbard 4107 Wilkens Ave. 21229	



1
B-516

67 2816

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2816

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIE MAE BENBOW

2. DATE AND HOUR PRONOUNCED DEAD

3-20-67

11:00 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3415 CHILDS COURT - Amb. Crew #9

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3415 Childs Court

21226

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

SEPARATED

8. DATE OF BIRTH

8-17-1926

9. AGE (in years last birthday)

40

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

MANNING S.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Spencer Robinson

14. MOTHER'S MAIDEN NAME

Ellen Harvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Anderson Bonbow

ADDRESS

18. 416X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-21-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3/28/67

23C. NAME OF CEMETERY or CREMATORY

St. Ambrose

23D. LOCATION (City, town, or county) (State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

MAR 23 1967

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Transit & Burial Co. 138 N. Green St.

ADDRESS

8-17-1946
Name: J.C.
Klein, Harry
Address: Boston

Spencer, Richard
Address: Boston
Separated

James
2/10/47
The Boston
Boston

48-90-03 1B

T-200 67 2817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

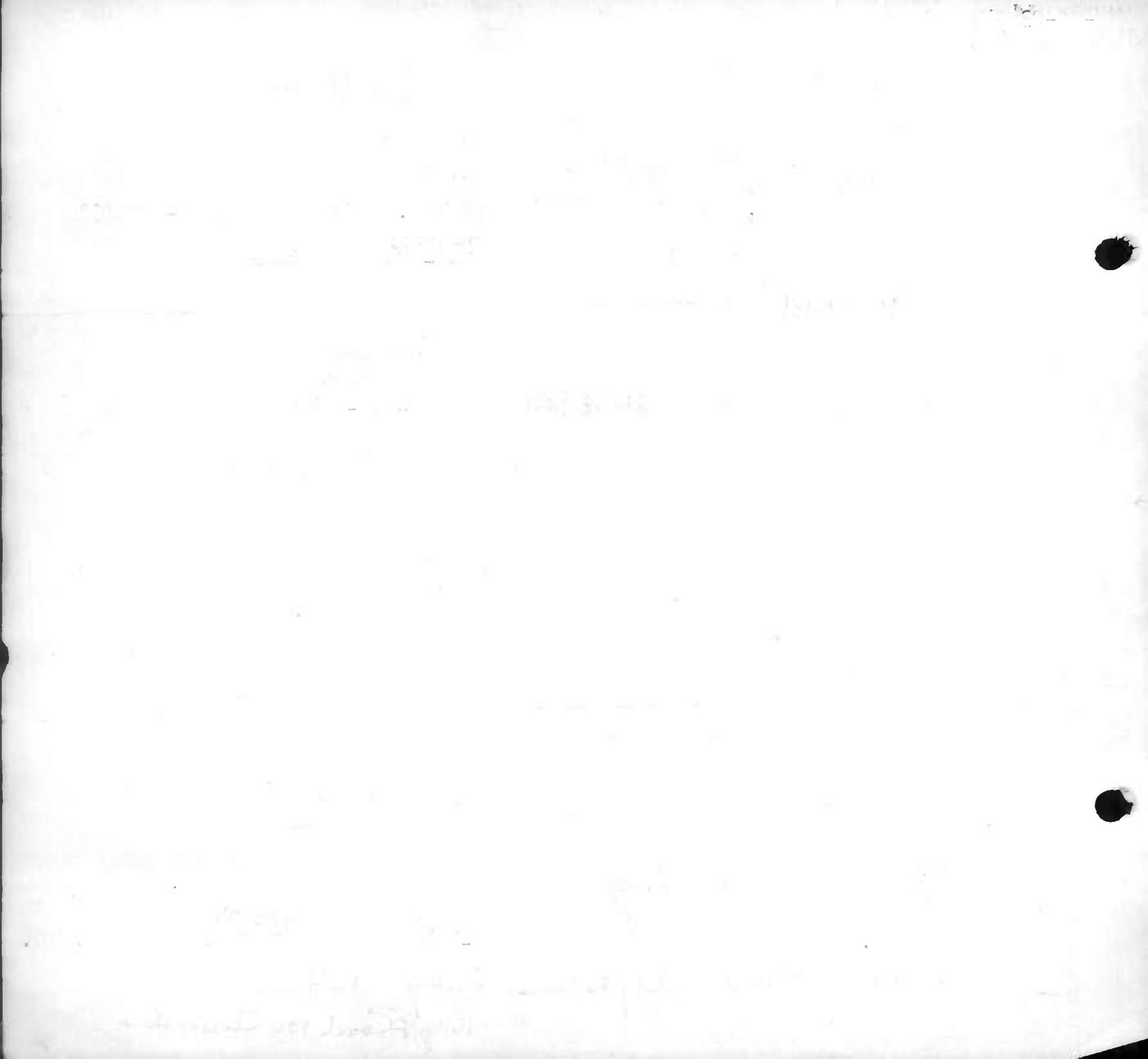
Registered No.

67 2817

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BESSIE MAY FOX		2. DATE AND HOUR OF DEATH 3/20/67 4 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1804 E. FAIRMOUNT AVENUE- #21231			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-27-03 11-6-07	9. AGE (In years lost birthday) 59-63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN LLOYD			14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214 18 9221		17. INFORMANT #21224 RECORDS-BCH-4940 EASTERN AVENUE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Shock, Renal shutdown				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypovolemia, possible sepsis				(C) Widespread Metastatic Ca. of Colon.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION Dec 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of colon		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/17 1967 to 3/20 1967 , that (1) (we) last saw the deceased alive on 3/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Terry Ersel Gagon M.D.				23B. DATE SIGNED 3/20/67		23C. PHYSICIAN'S NAME (Type) DR. TERRY ERSEL GAGON M.D.	
23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 3/23/67		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Philip F. Coyle		ADDRESS 124 Chesaco Ave.	



T-656

67 2818

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2818

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH A. TURNER

2. DATE AND HOUR PRONOUNCED DEAD

3-21-67

7:19 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

Baltimore Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)
9203 CHENOA Court 21234

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Sept 26 1946

9. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

US Gov.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HOWARD F. TURNER

14. MOTHER'S MAIDEN NAME

ANNE BEATTY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

219-44-5400

17. INFORMANT

ADDRESS

FAMILY RECORDS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Craniocerebral injury

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Expressway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Jones Falls Expressway - 500'

North of Pimlico Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 21 '67 7:05 AM

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto that ran off roadway

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

3-21-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/25/66

23C. NAME OF CEMETERY OR CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county)

Balto Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 23 1967

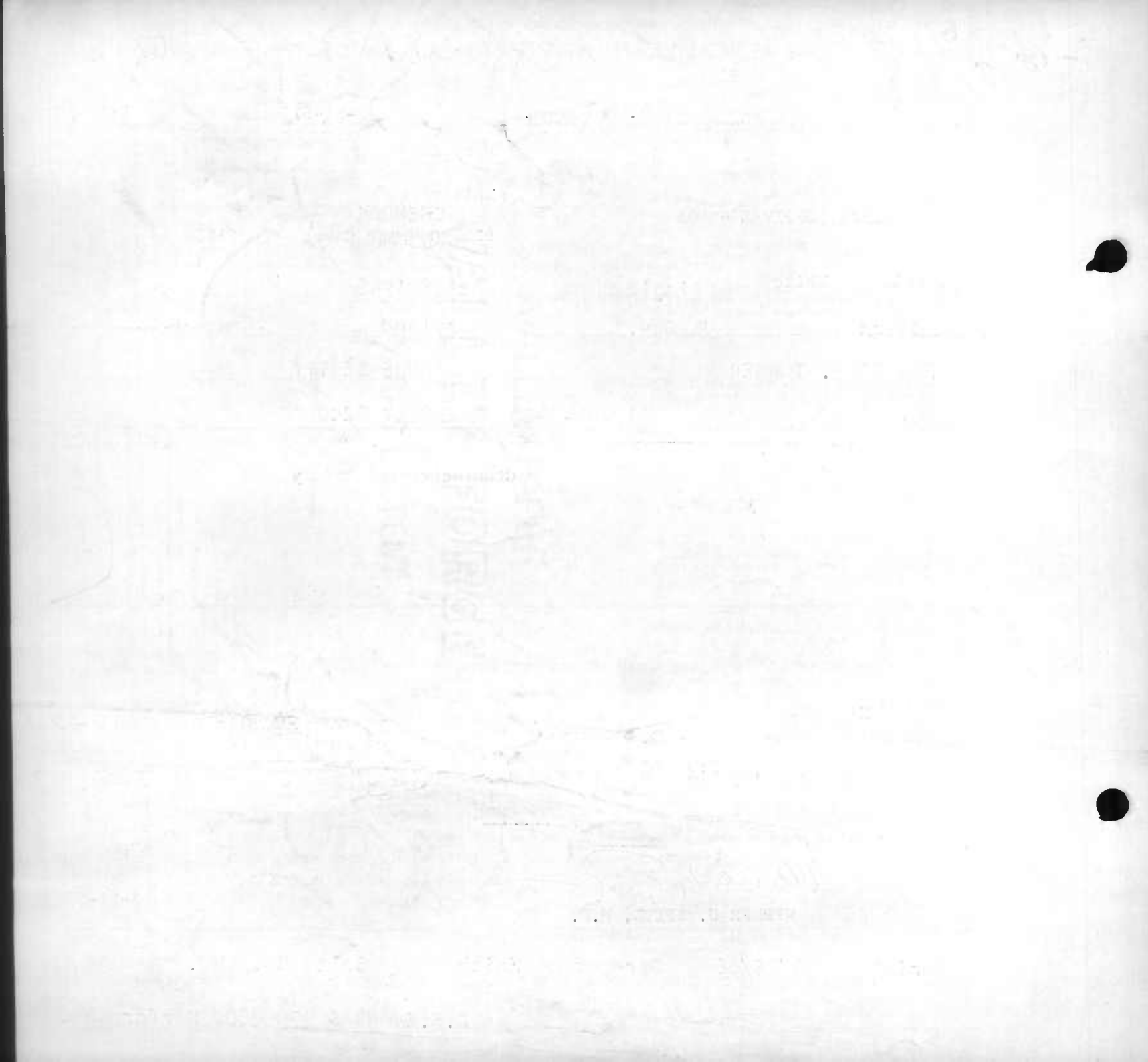
24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

ADDRESS

C.F. EVANS & SON 8802 Harford Rd.



15-315 67 2819

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2819

BIRTH NO. 67 2819		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Stevenson, Helen		2. DATE AND HOUR OF DEATH 3/15/67 6 ³⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BCH 4940 Eastern Avenue, Baltimore, Md. 21224		A. STATE Md B. COUNTY Balto	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 27-16	
		D. STREET ADDRESS (If rural, give location) 3408 St. Ambrose Ave. 21215	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) to married	8. DATE OF BIRTH 3-4-97
9. AGE (In years last birthday) 70		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME James D. Jones		14. MOTHER'S MAIDEN NAME Martha Reid	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 132-09-0205--	
		17. INFORMANT ADDRESS 21224 RECORDS: BCH, 4940 Eastern Ave., Balto. Md.	

18. 79501 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES	(A) DUE TO Acute MI vs pulm embolism	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO vs. pneumonia	
	(C)	

MEDICAL CERTIFICATION

19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/13/67 to 3/15/67, that (I) (we) last saw the deceased alive on 3/13/67 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. T. Davidson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/15/67			
23C. PHYSICIAN'S NAME (Type) J. T. Davidson M.D.				23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/67		24C. NAME of CEMETERY or CREMATORY St Charles		24D. LOCATION (City, town, or county) (State) Chance, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR William H. James III		25D. ADDRESS 258 Church St. Princess Anne, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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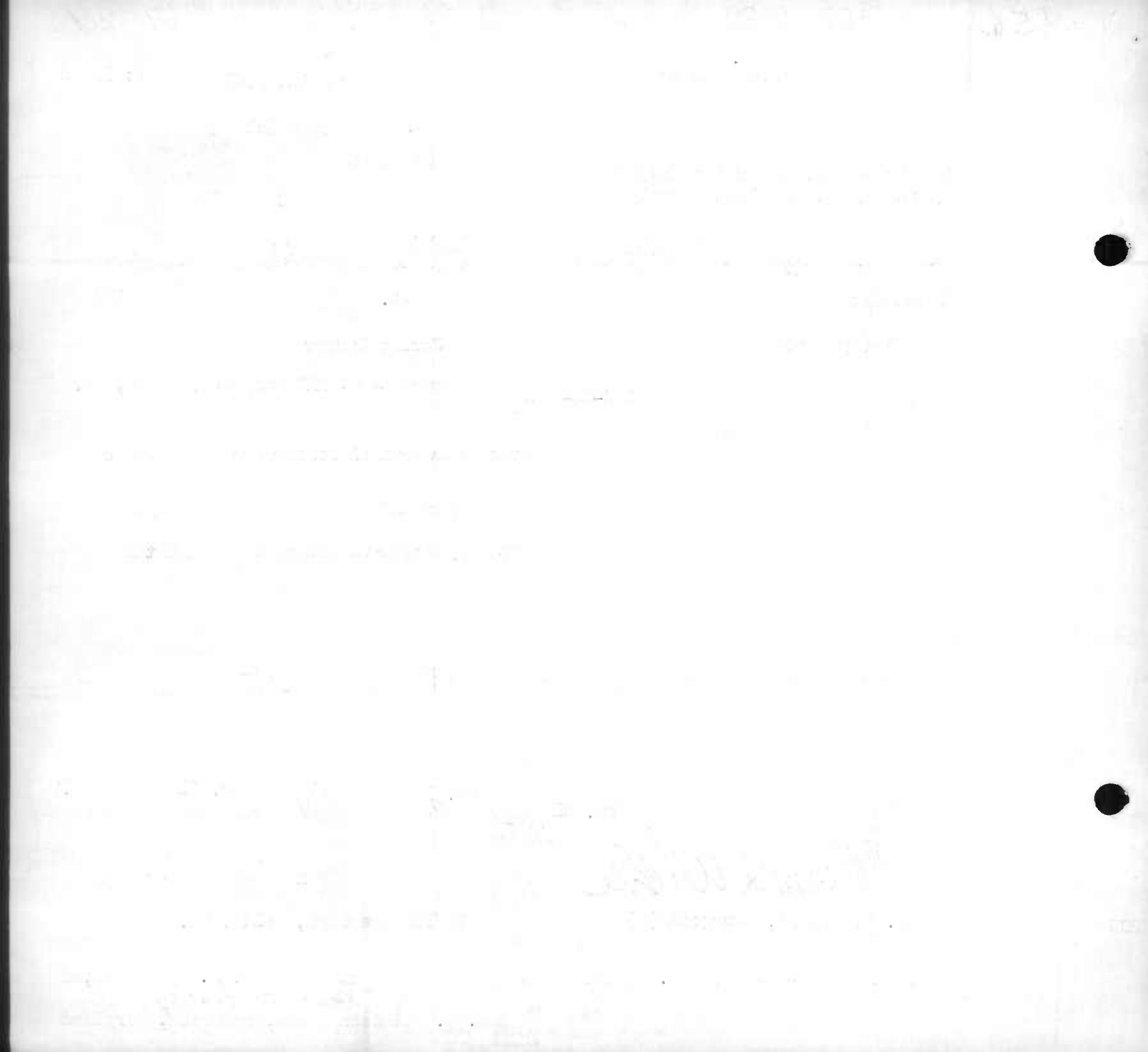
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2820		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2820	
1. NAME OF DECEASED (Type or Print) A. Rosalie Vollmer			2. DATE AND HOUR OF DEATH March 21, 1967 5: 35 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Frederick Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Frederick D. STREET ADDRESS (If rural, give location) Rt. 6 Box 200		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/15/26	9. AGE (In years lost birthday) 40	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harvey Davis			14. MOTHER'S MAIDEN NAME Jessie Darrow		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 204-14-9171	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. 20431 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) Acute intracranial hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Thrombocytopenia Acute myelogenous leukemia			INTERVAL BETWEEN ONSET AND DEATH Minutes Days Months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar. 3 19 67 to Mar. 21 19 67 , that (I) (we) last saw the deceased alive on Mar. 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Wilkie M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type) Wm. L. Wilkie, Surgeon (R)		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-1967		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery	
24D. LOCATION (City, town, or county) (State) Route 40 East, Frederick, Md		25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2821		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2821	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl Stetzen "B"		2. DATE AND HOUR OF DEATH 3/20/67 16⁵⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ESSEX 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital Baltimore, Md. 21231		D. STREET ADDRESS (If rural, give location) 6 HELICOPTER DR			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 3/19/67	9. AGE (In years last birthday) 27 hrs.	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ERNEST STETZEN		14. MOTHER'S MAIDEN NAME MARGARET COX	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ERNEST STETZEN	
18. 762.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Attacks of Lung, bilateral hrs.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Pneum. Pulmonary Hyaline membrane disease		(B) DUE TO	
(C) _____		(D) _____		(E) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. DATE OF OPERATION		19D. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/19 1967 to 3/20 1967 , that (I) (we) last saw the deceased alive on 3/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Francisco Baltazar, Jr. M.D.		23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR, JR. M.D.		23D. ADDRESS Church Home & Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 3/22/67		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR W. E. E. E.		25C. FUNERAL DIRECTOR St. Connelly Sons	
25D. ADDRESS 300 more		25E. ADDRESS		25F. ADDRESS	

General House & Hospital
La Grange, Ill. 4-12-31

W F

3/10/31

Bellevue, Ill.

ALL

The following report
is submitted for your
information & for the
purpose of being
recorded in the
files of the
Department.

Very respectfully,

Yours

James H. McGowan

Special Agent in Charge, U.S. Bureau of Investigation

F-520

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 2822		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2822	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
ANNETTE FINK		March 20, 1967 10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
3/ Baltimore City Hospitals		B. COUNTY Baltimore Co.	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		452 Stemmers Run Road	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER	8. DATE OF BIRTH DEC. 13, 1959
9. AGE (In years last birthday) 7		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL GIRL		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DONALD G. FINK SR.		14. MOTHER'S MAIDEN NAME MARTHA LUCAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injury.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N. Marlyn Ave., S. of Bennett Rd., Balto. Co.		21D. TIME OF INJURY (APPROX.) 3 17 '67 P	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by auto. 53-00	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED	
Charles S. Petty		3/20/67	
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE MAR 23 1967	
23C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH		23D. LOCATION (City, town, or county) (State) BALTO. MD	
24A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		24B. NAME OF REGISTRAR J. G. CONNELLY	
24C. FUNERAL DIRECTOR J. G. CONNELLY SONS		24D. ADDRESS 300 MACF	

MEMORANDUM

DATE: 10/10/50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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FUNERAL DIRECTOR: IMPORTANT

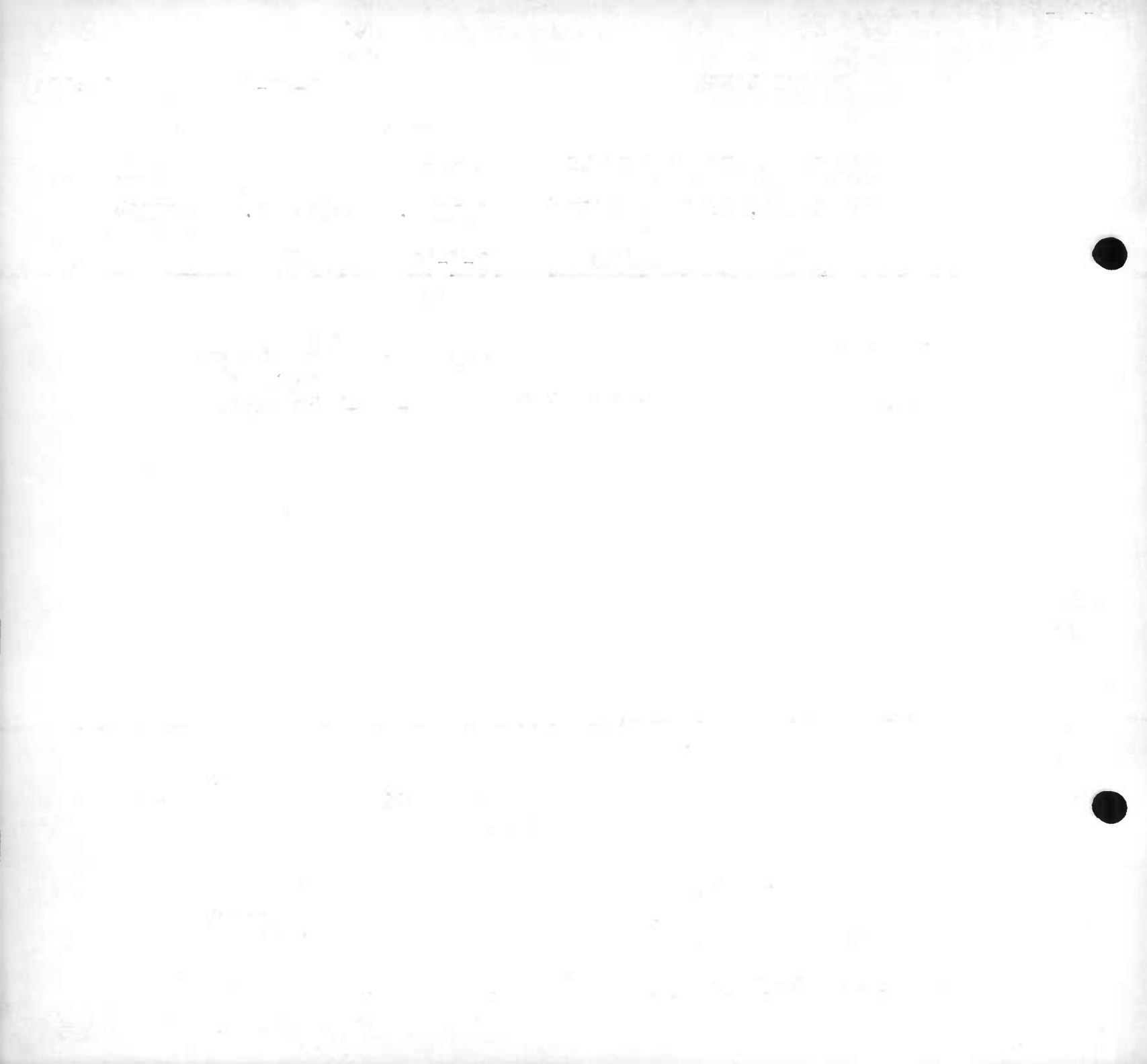
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2823		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2823	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) AGNES M. MARRIOTT		2. DATE AND HOUR OF DEATH 3-20-67 9:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		19-04	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1806 Mc HENRY ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7-18-79	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Benjamin Charles		14. MOTHER'S MAIDEN NAME Mary Gittelman		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. I 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) E.V.A.		CAUSE OF DEATH (A) DUE TO ASCVD.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-9 19 67 to 3-20 19 67, that (I) (we) lost saw the deceased olive on 3-20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas C. Vidayaphum		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-20-67	
23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDAYAPHUM		23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/67		24C. NAME OF CEMETERY or CREMATORY Mt Olive	
24D. LOCATION (City, town or county) (State) Baltimore County Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Walter Funeral Home Pratt & Strickland St.			

1900

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2824		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2824	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) JULIUS LANGE		2. DATE AND HOUR OF DEATH 3-20-67 12:30AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-08			
D. STREET ADDRESS (If rural, give location) 3512 E. LOMBARD ST. #21224							
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-6-99	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert				14. MOTHER'S MAIDEN NAME Louisa Mardaga			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-5242		17. INFORMANT #21224		ADDRESS RECORDS-BCH-4940 EASTERN AVENUE	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO ASCVD (B) DUE TO Diabetes Mellitus (C)		INTERVAL BETWEEN ONSET AND DEATH years years.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/13/68 19 to 3/20/67 19, that (I) (we) last saw the deceased alive on 3/20/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bruce M. Dow				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/20/67	
23C. PHYSICIAN'S NAME (Type) Bruce M. Dow				23D. ADDRESS BCH. #21224 4940 EASTERN AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Thelma A. Hoffman		ADDRESS 3218 Huguenot	



D-553

67 2825
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2825

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GEORGE LYWOOD DEMENT				2. DATE AND HOUR PRONOUNCED DEAD March 16, 1967 8:40 A			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY ST. MARY'S C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) California 68-00 D. STREET ADDRESS (If rural, give location)			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 14, 1909	9. AGE (In years last birthday) 57	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Dement				14. MOTHER'S MAIDEN NAME Lena Russell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DORIS L. DEMENT CALIFORNIA, MARYLAND			
18. E816.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Multiple Injuries. DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Callaway, Md. - St. Mary's County			
21D. TIME OF INJURY (APPROX.) 3 8 '67 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver in auto-auto collision. 68-00			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/16/67							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE MARCH 18, 1967		23C. NAME of CEMETERY or CREMATORY HOLY FACE CEMETERY		23D. LOCATION (City, town, or county) (State) GREAT MILLS, ST. MARY'S, MD.	
24A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR ADDRESS W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 2826					REGISTERED NO. 67 2826				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) EDNA CATHERINE SHREET					2. DATE AND HOUR OF DEATH March 17, 1967 7 a.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Nursing Home					A. STATE Md. B. COUNTY 21212				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
D. STREET ADDRESS (If rural, give location) 1300 Highland Drive					E. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00				
5. SEX female		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 3/10/1886		9. AGE (In years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME James Schofield					14. MOTHER'S MAIDEN NAME Mary Demitz				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 215-0907203D					17. INFORMANT ADDRESS Ruth Tenley, dght, above				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 350X I					CAUSE OF DEATH (A) DUE TO Coronary Artery				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO Portneurotic Disease				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO Hypertension, Arteriosclerosis, Heart Disease				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) No.					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 1946 to March 17 1967 , that (I) (we) last saw the deceased alive on 3-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William L. Fearing					23B. DATE SIGNED 3-21-67				
23C. PHYSICIAN'S NAME (Type) Dr. William Fearing					23D. ADDRESS 3025 Belair Road				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 3/21/67				
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE RECEIVED BY HEALTH DEPT. MAR 23 1967					25B. NAME OF REGISTRAR Robert E. Taylor				
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.					ADDRESS 3331 Brehms Lane				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 2827	
BIRTH NO. 67 2827		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED Rev. Joseph J. Leary						2. DATE AND HOUR OF DEATH 3-20-67 1:50 A.M.			
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21228			
								D. STREET ADDRESS (If rural, give location) 30 MELVIN AVENUE 53-00			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 10-9-95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (USGR) - PRIEST		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME FRANCIS LEARY				14. MOTHER'S MAIDEN NAME ANNA WALSH							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Rev. Henry J. Hughes - 30 Melvin Ave.				ADDRESS			
18. 5411 I		CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) perforated duodenal ulcer									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) peritonitis									
		(C)									
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 3-12-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Duodenal Ulcer		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 3-12-67 to 3-20-67 , that (I) (we) last saw the deceased alive on 3-19-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE James K. K... M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 20, 1967			
23C. PHYSICIAN'S NAME (Type) ju		23D. ADDRESS M.D. Bon Secours Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-67		24C. NAME of CEMETERY or CREMATORY Cathedral Am.		24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR John Cunningham		ADDRESS St. Catonsville, Md.					

Dr James H. ...

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John H. ...

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Dr James H. ...

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FUNERAL DIRECTOR: IMPORTANT

icate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2828		CERTIFICATE OF DEATH		Registered No. 67 2828	
1. NAME OF DECEASED (Type or Print) Teresa Redihan			2. DATE AND HOUR OF DEATH 3-22-67 1:00 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 21 The Seton Psychiatric Institute 6420 Reisterstown Road Baltimore, Maryland 21215			A. STATE Maryland B. COUNTY (Baltimore City)		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28-41		
			D. STREET ADDRESS (If rural, give location) Seton Institute, Baltimore 21215		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 2-10-74	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Providence, Rhode Island	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME John Redihan		
14. MOTHER'S MAIDEN NAME Marie McGovern			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no		
16. SOCIAL SECURITY NO. 220-54-6941			17. INFORMANT ADDRESS records Seton Institute (Balto.-21215)		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) General & cerebral arteriosclerosis 10 yrs.			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Chronic myocardial degeneration about 4 yrs.		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Chronic undifferentiated schizophrenic reaction 52 yrs.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 21, 1917 to March 22, 1967 , that (I) (we) last saw the deceased alive on March 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter O. Jahrrheis			M.D. Attending Phys. <input type="checkbox"/> for Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED March 22, 1967
23C. PHYSICIAN'S NAME (Type) Walter O. Jahrrheis			23D. ADDRESS 6420-Reisterstown Rd. Balto-21215		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE Mar-23-67		24C. NAME of CEMETERY or CREMATORY Old St. Mary's	
24D. LOCATION Pawtucket, Rhode Island.		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR-23-1967		25B. NAME OF REGISTRAR Walter O. Jahrrheis		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co. 108-W-North-Av. 21201	



CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2829		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) George Foreman		2. DATE AND HOUR OF DEATH 20 March 1967 2:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 31 4940 Eastern Avenue Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2318 McCulloh Street #21217	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 25 Nov. 1980
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 86
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Unknown	
16. SOCIAL SECURITY NO.		17. INFORMANT BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224	
18. 151X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of the Stomach		INTERVAL BETWEEN ONSET AND DEATH 4 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema		(C) DUE TO	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20A. AUTOPSY? (Yes or No) NO	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 13 February 1967 to 20 March 1967 , that (I) (we) last saw the deceased alive on 20 March 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Alan J. Barnes		23B. DATE SIGNED 20 March 1967	
23C. PHYSICIAN'S NAME (Type) Alan J. Barnes		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/67	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT					Registered No. 67 2830	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 2830 CERTIFICATE OF DEATH </div>						
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Miriam G. Tormey				2. DATE AND HOUR OF DEATH March 19, 1967 1.30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines 2525 Belvedere Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1913 Chelsea Rd.		
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 1, 1896	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph A. Gunther			14. MOTHER'S MAIDEN NAME Regina Dumlér			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-0453		17. INFORMANT Mr. Charles M. Gunther 1913 Chelsea Rd. - 21216		ADDRESS
18. I 70 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Broncho pneumonia DUE TO (B) Metastatic Spine Carcinoma DUE TO (C) Malignancy of Breast (left)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 yr 13 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebro-Vascular Accident July 1966						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from January 1955 to March 19 1967, that (I) (we) last saw the deceased alive on March 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE M. W. Jacobson				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-21-67
23C. PHYSICIAN'S NAME (Type) M. W. Jacobson		23D. ADDRESS 6821 Reisterstown Rd.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-67	24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		

Page 10, 1950

Page 10, 1950

1015 Orleans St.
Chicago, Ill.

1015 Orleans St.
Chicago, Ill.

June 1, 1950 TO

June 1, 1950 TO

Chicago

Chicago

Chicago

Chicago

Mr. Charles H. Gurnea
1015 Orleans St. - 21210
Chicago, Ill.

Mr. Charles H. Gurnea

Mr. Charles H. Gurnea

Chicago, Ill.

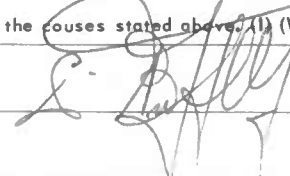
Chicago, Ill.

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Chicago, Ill.

Chicago, Ill.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 2831</u>	
BIRTH NO. <u>400 67 2831</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HILL, HOMER</u>	
2. DATE AND HOUR OF DEATH <u>MARCH 20 1967</u> <u>5 10</u> <u>A M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u> <u>42</u>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>BALTIMORE 5110 Cordelia Ave.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/4/10</u>
9. AGE (In years last birthday) <u>57</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>USA. - W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Late - Lee Hill</u>		14. MOTHER'S MAIDEN NAME <u>Late - Nettie ---</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Clayton Simmons</u> <u>3216 Lake Ave. - 21213</u>
18. <u>502.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE - Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHRONIC BRONCHITIS</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>METABOLIC DISORDERS and low SALT SYNDROME 20 to chronic vomiting</u> <u>CHRONIC MALNUTRITION</u>	
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO.</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/17 1967</u> to <u>3/20 1967</u> , that (I) (we) last saw the deceased alive on <u>3/20 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <u>3/20/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. F. D. Witzke</u>		23D. ADDRESS <u>Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3-23-67</u>	24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1967</u>		25B. NAME OF REGISTRAR <u>W. F. D. Witzke</u>	
25C. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CITY HEALTH DEPARTMENT									
CITY HEALTH DEPARTMENT									
BIRTH NO. 67 2832		CITY HEALTH DEPARTMENT							
M.E. CASE NO.		CITY HEALTH DEPARTMENT							
1. NAME OF DECEASED (Type or Print)		Eva E. Trainor				2. DATE AND HOUR OF DEATH		March 21, 1967 11:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
228 Stonecroft Rd.		Md.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
00		D. STREET ADDRESS (If rural, give location)				228 Stonecroft Rd.		28-04	
5. SEX	F	6. RACE	Cauc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	Married	8. DATE OF BIRTH	Sept. 22/08	9. AGE (In years last birthday)	58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife				Balto., Md.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Jacob Foster		Mary Tracey						Mr. Eugene A. Trainor, Jr.	
								518 Murdock Rd. - 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH					
420.1 & 170X		Cardiac arrest		Sudden					
ANTECEDENT CAUSES		(A) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		Immediate					
		(C) disease		Several yrs.					
II		Carcinoma of right breast		4 months					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) physician attended the deceased from July 26, 19 61 to March 21, 19 67.		that (I) last last saw the deceased alive on March 19, 19 67 and that in (my) own opinion death occurred on the date		and hour and from the causes stated above. (I) did (did) not view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
S. J. Liu		3/22/67		S. J. Liu		5301 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		3-22-67		Loudon Park Cem.		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 23 1967		Robert E. Taylor, M.D.		Witzke F. D.		4101 Edmondson Ave.			

BALTIMORE

March 21, 1962

Mr. Tolson

Mr. DeLoach

Mr. Mohr

Mr. Bishop

Mr. Casper

Mr. Callahan

Mr. Conrad

Mr. Felt

Mr. Gale

Mr. Rosen

Mr. Sullivan
Mr. Tavel
Mr. Trotter
Mr. Tele. Room
Mr. Holmes
Miss Gandy

Mr. W.C. Sullivan

Mr. J. Edgar Hoover

Mr. DeLoach
Mr. Mohr
Mr. Bishop
Mr. Casper
Mr. Callahan
Mr. Conrad
Mr. Felt
Mr. Gale
Mr. Rosen
Mr. Sullivan
Mr. Tavel
Mr. Trotter
Mr. Tele. Room
Mr. Holmes
Miss Gandy

Mr. DeLoach

Mr. DeLoach

Mr. DeLoach

Mr. DeLoach

Mr. DeLoach

Mr. DeLoach

Mr. DeLoach

Mr. DeLoach

Mr. DeLoach

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 2833					CERTIFICATE OF DEATH					Registered No. 67 2833				
1. NAME OF DECEASED (Type or Print) <i>Weiss, Mary Elizabeth</i>										2. DATE AND HOUR OF DEATH <i>3/20/67 2 P</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Gould Convalesarium</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 6-01</i> D. STREET ADDRESS (If rural, give location) <i>146 N. Ellwood Ave.</i>				
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>12/31/1900</i>		9. AGE (In years lost birthday) <i>66</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>MR. K. A. Weiss Jr.</i>					ADDRESS <i>146 N. Ellwood Ave.</i>		
18. <i>79-381</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Atelostat Pneumonia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>Infection</i>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Brain Syndrome</i>														
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 8 19 67</i> to <i>March 20 19 67</i> , that (I) (we) last saw the deceased alive on <i>March 9 19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>Albert B. Brashley</i>										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/20/67</i>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			24B. DATE <i>3/25/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem. BALTO. MD.</i>			24D. LOCATION (City, town, or county) (State)						
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. Seaborn</i>					25C. FUNERAL DIRECTOR <i>B. DABROWSKI 2818 E. BALTIMORE ST.</i>				

141 N. Ellwood Ave
Baltimore

md

Howe

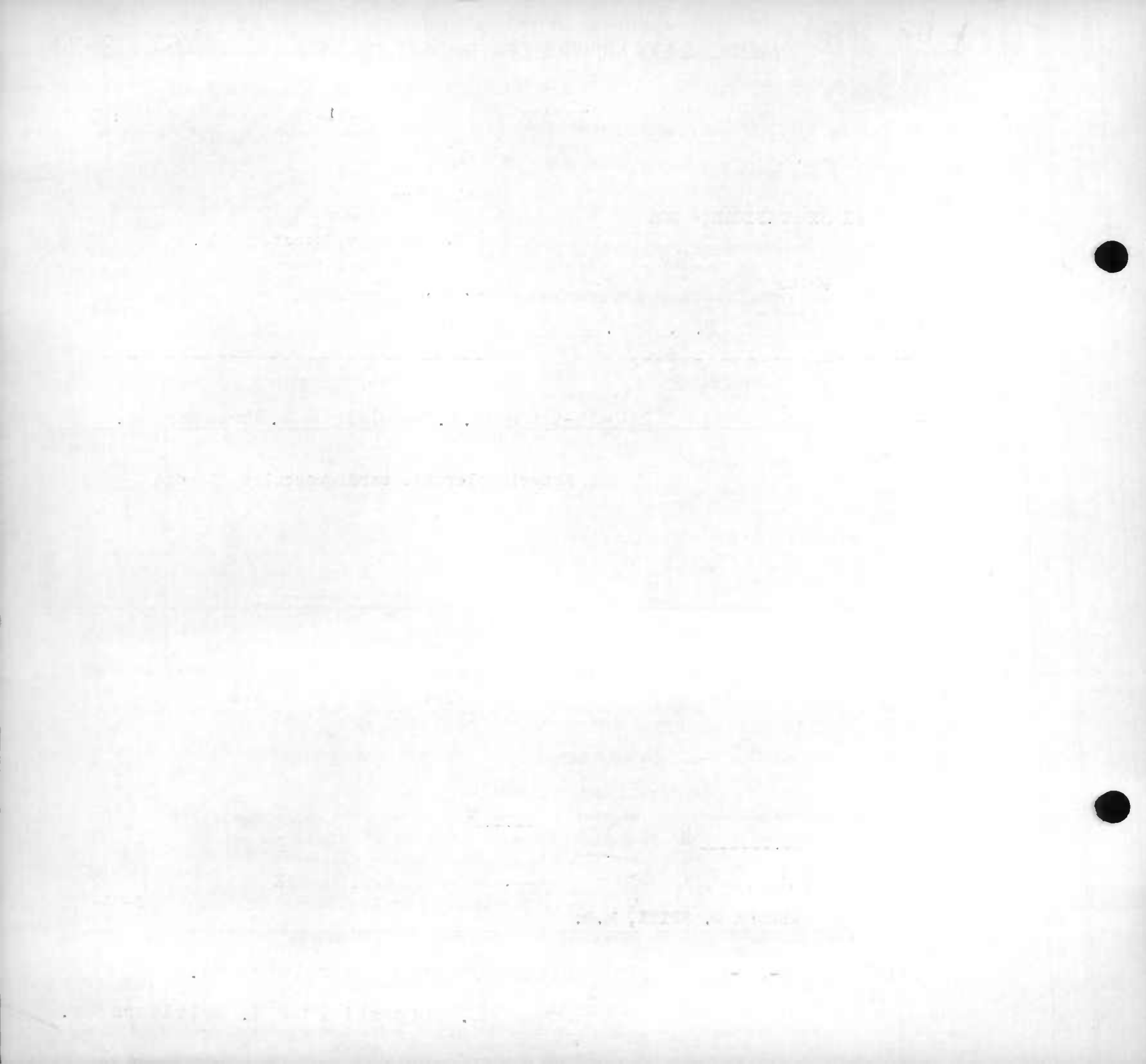
Mr. K. A. V. 123 N. Ellwood Ave

8-5174
G. O. G. 123 N. Ellwood Ave
Baltimore

1
T-340

<p>67 2834</p> <p>BIRTH NO.</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2834</p>	
<p>M.E. CASE NO.</p>		<p>2. DATE AND HOUR PRONOUNCED DEAD</p> <p style="text-align: right;">3-20-67 1:00 PM.</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">RAYMOND TWEEDALE</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY _____</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="text-align: center;">42 99 SINAI HOSPITAL - DOA</p>		<p>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)</p> <p style="text-align: center;">Baltimore</p> <p>D. STREET ADDRESS (If rural, give location)</p> <p style="text-align: center;">4 N. Streeper Street 21224</p>	
<p>5. SEX</p> <p style="text-align: center;">Male</p>	<p>6. RACE</p> <p style="text-align: center;">White</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p>	<p>8. DATE OF BIRTH</p> <p style="text-align: center;">Nov. 16, 1921</p>
<p>9. AGE (In years last birthday)</p> <p style="text-align: center;">46</p>		<p>If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="text-align: center;">Mailman</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="text-align: center;">U.S. Gov.</p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p style="text-align: center;">Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME</p> <p>-----</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p>-----</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center;">WW-2</p>		<p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center;">220-05-9449</p>	
<p>17. INFORMANT</p> <p style="text-align: center;">Mrs. A. Tweedale</p>		<p>ADDRESS</p> <p style="text-align: center;">4 N. Streeper St.</p>	
<p>18. CAUSE OF DEATH</p> <p style="text-align: center;">422.1 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">(A) Arteriosclerotic cardiovascular disease</p> <p>DUE TO</p> <p style="text-align: center;">(B) _____</p> <p>DUE TO</p> <p style="text-align: center;">(C) _____</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION</p> <p style="text-align: center;">2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p style="text-align: center;">Yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p style="text-align: center;">Yes</p>	
<p>21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p style="text-align: right;">CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p style="text-align: right;">DATE SIGNED 3-21-67</p>			
<p>23A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="text-align: center;">Burial</p>		<p>23B. DATE</p> <p style="text-align: center;">3-27-67</p>	
<p>23C. NAME of CEMETERY or CREMATORY</p> <p style="text-align: center;">Holy Redeemer Cemetery</p>		<p>23D. LOCATION (City, town, or county) (State)</p> <p style="text-align: center;">Baltimore Md.</p>	
<p>24A. DATE REC'D BY HEALTH DEPT.</p> <p style="text-align: center;">MAR 23 1967</p>		<p>24B. NAME OF REGISTRAR</p> <p style="text-align: center;">Robert E. Fisher</p>	
<p>24C. FUNERAL DIRECTOR</p> <p style="text-align: center;">B. Dabrowski</p>		<p>ADDRESS</p> <p style="text-align: center;">2818 E. Baltimore St.</p>	

19670502012



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

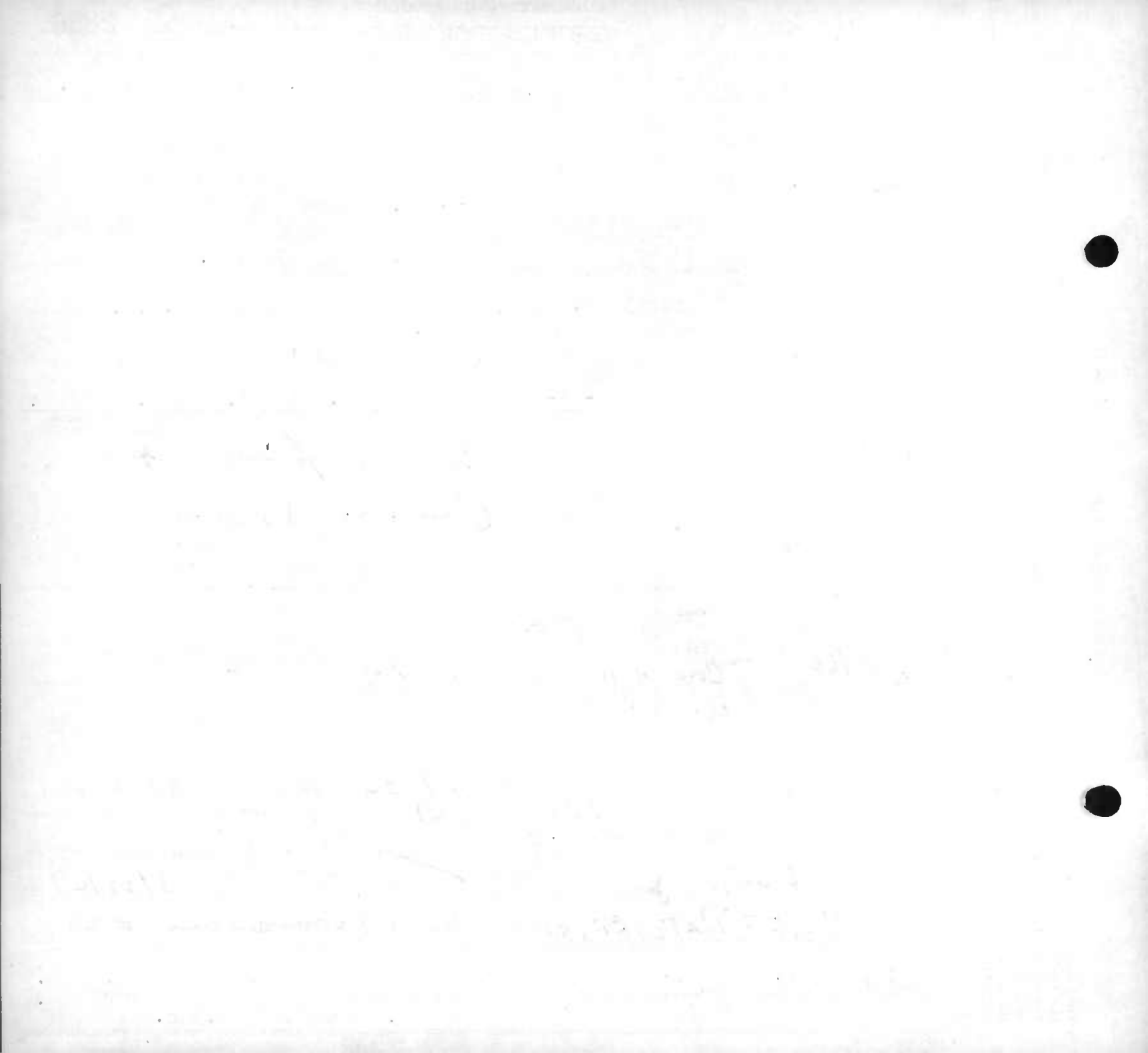
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2835</u>	
BIRTH NO. <u>67 2835</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Oliver Clark</u>		2. DATE AND HOUR OF DEATH <u>3-20-1967</u> <u>9:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>25</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #21226 06</u>			
		D. STREET ADDRESS (If rural, give location) <u>3320 REMLEY AVE.</u>			
5. SEX <u>M.</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-15-10</u>	9. AGE (In years, last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>odd jobs.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>	
13. FATHER'S NAME <u>John Clark</u>		14. MOTHER'S MAIDEN NAME <u>Emma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-019271</u>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>307X</u>		CAUSE OF DEATH (A) DUE TO <u>Lobar pneumonia, left lower lobe</u> (B) DUE TO <u>Alcoholic delirium tremens</u> (C) <u>Chronic Bronchitis - Laennec's</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wh.</u> <u>1 wh.</u> <u>?</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(Lower carcinoma)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from <u>3-16</u> 19 <u>67</u> to <u>3-20</u> 19 <u>67</u> , that (we) last saw the deceased alive on <u>3-20</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. G. Arellano</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-20-67.</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERTO G. ARELLANO</u>		23D. ADDRESS <u>SOUTH BALTIMORE GEN. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/25/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Int. Calvary Cemetery</u>	
24D. LOCATION (City, town or county) (State) <u>A.A. Co. Ind</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Williams</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1701-34 Bond St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2836		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2836	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Mary Weber			March 22, 1967 5:45 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 401 S. Chester Street			A. STATE Maryland B. COUNTY Baltimore		
5. SEX Female			6. RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH August 3, 1894		
9. AGE (In years last birthday) 72 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		
11. BIRTHPLACE (State or foreign country) Poland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Jankowiak			14. MOTHER'S MAIDEN NAME Rose Nowakowski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-34-3086		
17. INFORMANT Geraldine W. Holter, 401 S. Chester			ADDRESS		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure 4 days					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of pancreas 1 yr					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 05/23/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of pancreas		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/26/60 to 3/22/67, that (I) (we) last saw the deceased alive on 3/18/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Cliff Ratliff, Jr.			23B. DATE SIGNED 3/22/67		
23C. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR. M.D.			23D. ADDRESS 4605 Edmondson Ave #29 Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/67		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus	
24D. LOCATION German Hill Road, Balto		24E. DATE REC'D BY HEALTH DEPT. MAR 23 1967		24F. NAME OF REGISTRAR Robert E. Jackson	
24G. FUNERAL DIRECTOR John M. Weber & Sons, Inc.		24H. ADDRESS 401 S. Chester			



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W-452

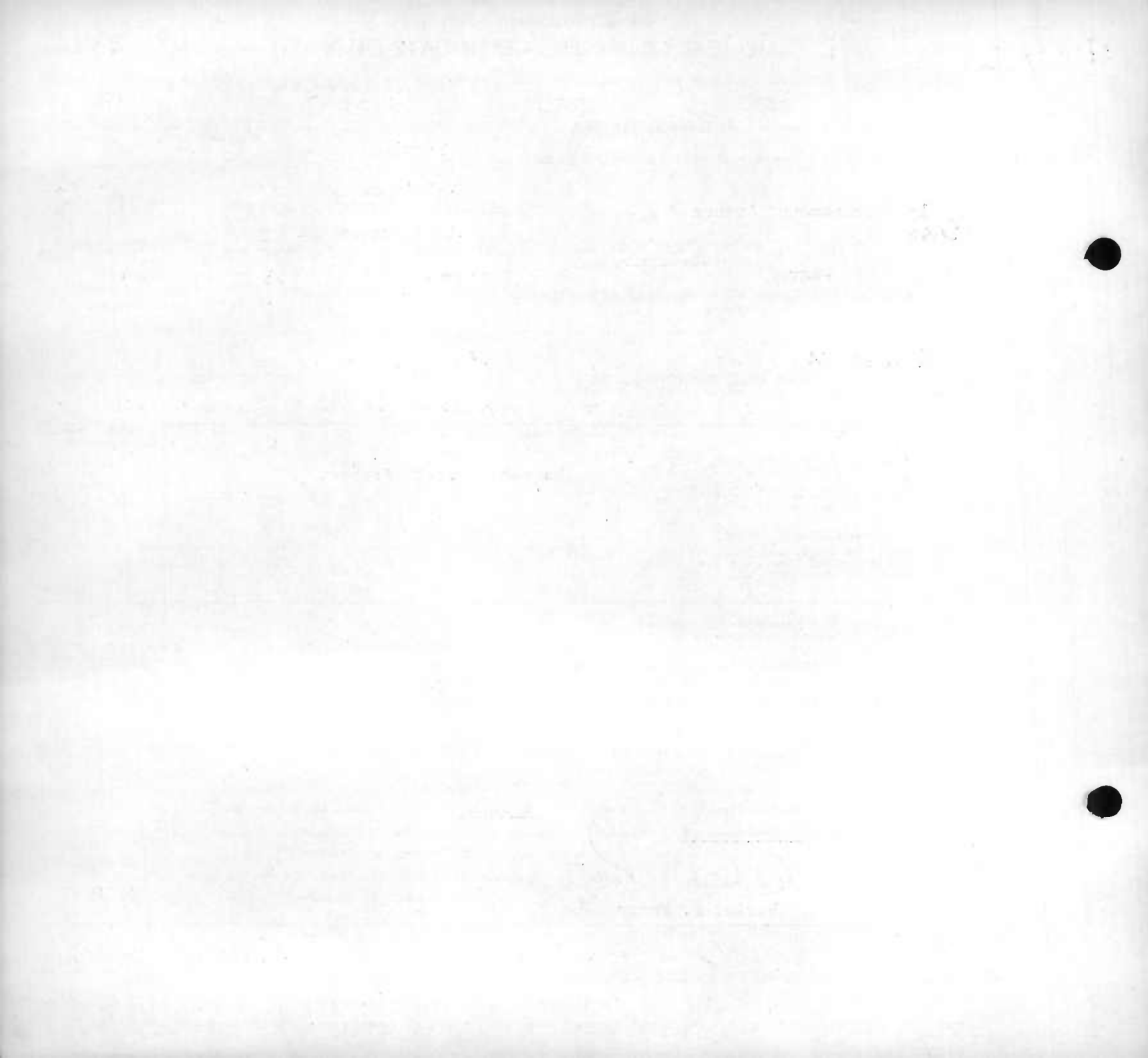
67 2837

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2837

1. NAME OF DECEASED (Type or Print)		BOYCE Lee WILLIAMS		2. DATE AND HOUR PRONOUNCED DEAD March 19, 1967 11:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 1924 Greenmount Avenue				A. STATE Maryland B. COUNTY Baltimore 12-04	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Williams				14. MOTHER'S MAIDEN NAME Penny Farrar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-304617		Robert Williams 2206 Greenmount Ave	
18. CAUSE OF DEATH					
I 416 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
(A) Rheumatic Heart Disease. DUE TO					
(B) DUE TO					
(C) DUE TO					
INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		Charles S. Petty		M.D.	
EXAMINER'S NAME (Type)		Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		3/23/67		Mt. Calvary Cem	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
MAR 23 1967		Robert E. Finkbeiner		Wm MARCH 928 E. North Ave	
				24D. LOCATION (City, town, or county) (State)	
				Anne Arundel Cty. Md.	

19670002845



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2839	
BIRTH NO. 67 2839		M.E. CASE NO. Elizabeth		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Elizabeth Davis			2. DATE AND HOUR OF DEATH 21 May 67 8:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Fayette Convalescent Home 1105 E. FAYETTE ST.			A. STATE Md B. COUNTY Balt		
5. SEX Female			6. RACE Col		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH Oct 14, 1895		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Groves Virginia		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212 10 1005 (B)		
17. INFORMANT Nephew			ADDRESS 2140 E Federal St 21213		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO Multiple CVA		
ANTECEDENT CAUSES			(B) DUE TO ASCVD		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Retinopathy, arcus, cataracts					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1st Mar 1967 to 21 Mar 1967, that (I) (we) last saw the deceased alive on 21 Mar 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J Huller				23B. DATE SIGNED 21 Mar 67	
23C. PHYSICIAN'S NAME (Type) J Huller				23D. ADDRESS 2214 E Fayette St 21281	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR 1129 H. CAROLINE ST	

11-1-1911

Print for Home

FUNERAL DIRECTOR: IMPORTANT

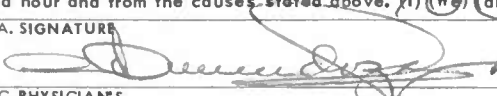
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2840		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2840	
M.E. CASE NO.		1. NAME OF DECEASED <i>Pigatt, George</i>		2. DATE AND HOUR OF DEATH <i>3/21 - 1967 7:33 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>335 HH</i> THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>8.05</i> D. STREET ADDRESS (If rural, give location) <i>1904 E. Lafayette Ave</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>2-22-28</i>	9. AGE (In years, lost birthday) <i>39</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Refactory Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>USA Rye Ford, N.C.</i>	
13. FATHER'S NAME <i>BOOKER T. BRIDGES</i>		14. MOTHER'S MAIDEN NAME <i>THEOLA PIGATT</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>1904 E. LAFAYETTE</i> <i>ETHEL PIGATT</i>	
18. I <i>199-2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Metastatic Carcinoma</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(I)</i> (this hospital) attended the deceased from <i>3/17</i> 19 <i>67</i> to <i>3/21</i> 19 <i>67</i> , that <i>(I)</i> (we) last saw the deceased alive on <i>3/21</i> 19 <i>67</i> and that in <i>(my)</i> <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> <i>(We)</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rabb Moses</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/21/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rabb Moses</i>		23D. ADDRESS <i>JHH THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>March 25/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Milton E. Elickson 1129 N. Carroll St</i>	



FUNERAL DIRECTOR: IMPORTANT

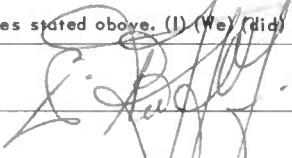
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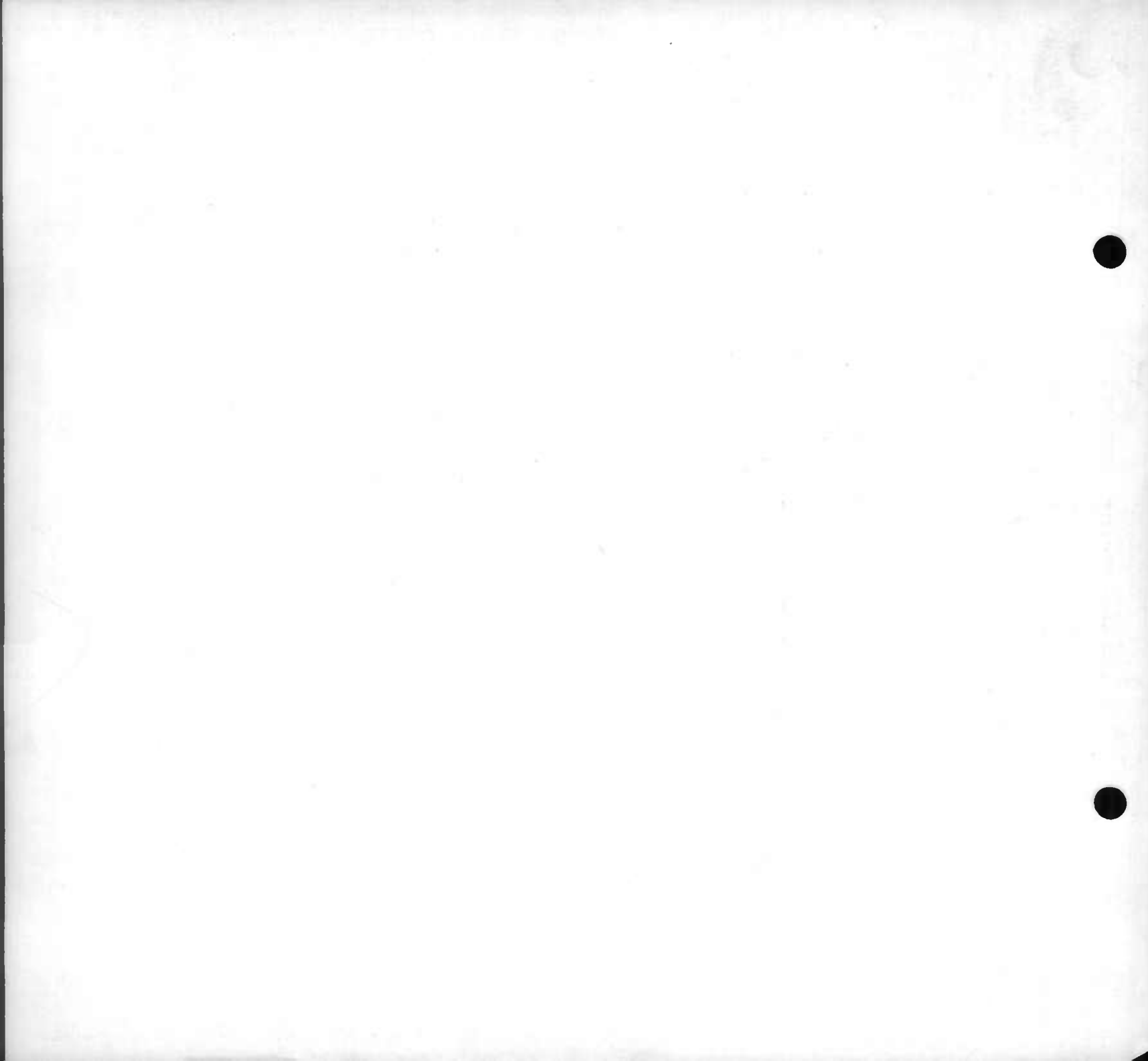
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2841	
BIRTH NO. 67 2841		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Thayer, Frank Albert, Sr.		2. DATE AND HOUR OF DEATH 3-22-67 10:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 20-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2001 McHenry Street	
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-04-95	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10B. KIND OF BUSINESS OR INDUSTRY Residential		11. BIRTHPLACE (State or foreign country) Adams town, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Thayer		14. MOTHER'S MAIDEN NAME Mary Butler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO. 219-03-6232		17. INFORMANT ADDRESS CATHERINE Thayer 2001 McHenry St.	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Myocardial Infarct, Ant. Wall DUE TO		3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Heart Disease DUE TO		years	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (This hospital) attended the deceased from March 9 1967 to March 22 1967 , that (1) (we) last saw the deceased alive on March 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D.				23B. DATE SIGNED 3/22/67	
23C. PHYSICIAN'S NAME (Type) A.A. MENDOZA		23D. ADDRESS BON SECOURS HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-27-67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD		25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Geo. L. Schwab FUNERAL HOME Francis W. Miller 2101 Frederick Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W 6231 BIRTH NO. 67 2842 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 67 2842			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) WRIGHT, JOHN C.		2. DATE AND HOUR OF DEATH MARCH 21 1967 10³⁵ AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4251 HOSPITAL INC		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 12-0-5 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2016 St PAUL Street	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 4/9/97
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 69
11. BIRTHPLACE (State or foreign country) Va. USA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GARNETT FRANCIS WRIGHT		14. MOTHER'S MAIDEN NAME MARTHA SUSIE HOY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-0967	
17. INFORMANT LeRoy C. Wright		ADDRESS 2014 St PAUL Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC OBSTRUCTIVE LUNG DISEASE (EMPHYSEMA)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC BRONCHITIS (BRONCHIECTASIS)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/18/1967 to 3/21/1967 , that (I) (we) last saw the deceased alive on 3/21/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED MARCH 21 1967	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3-25-67	24C. NAME OF CEMETERY OR CREMATORY St. Mary's Crematory	24D. LOCATION (City, town, or county) (State) Hamden Balt. City Md.
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Wm. Cooke Brooks Inc. 1217 St. PAUL St.	

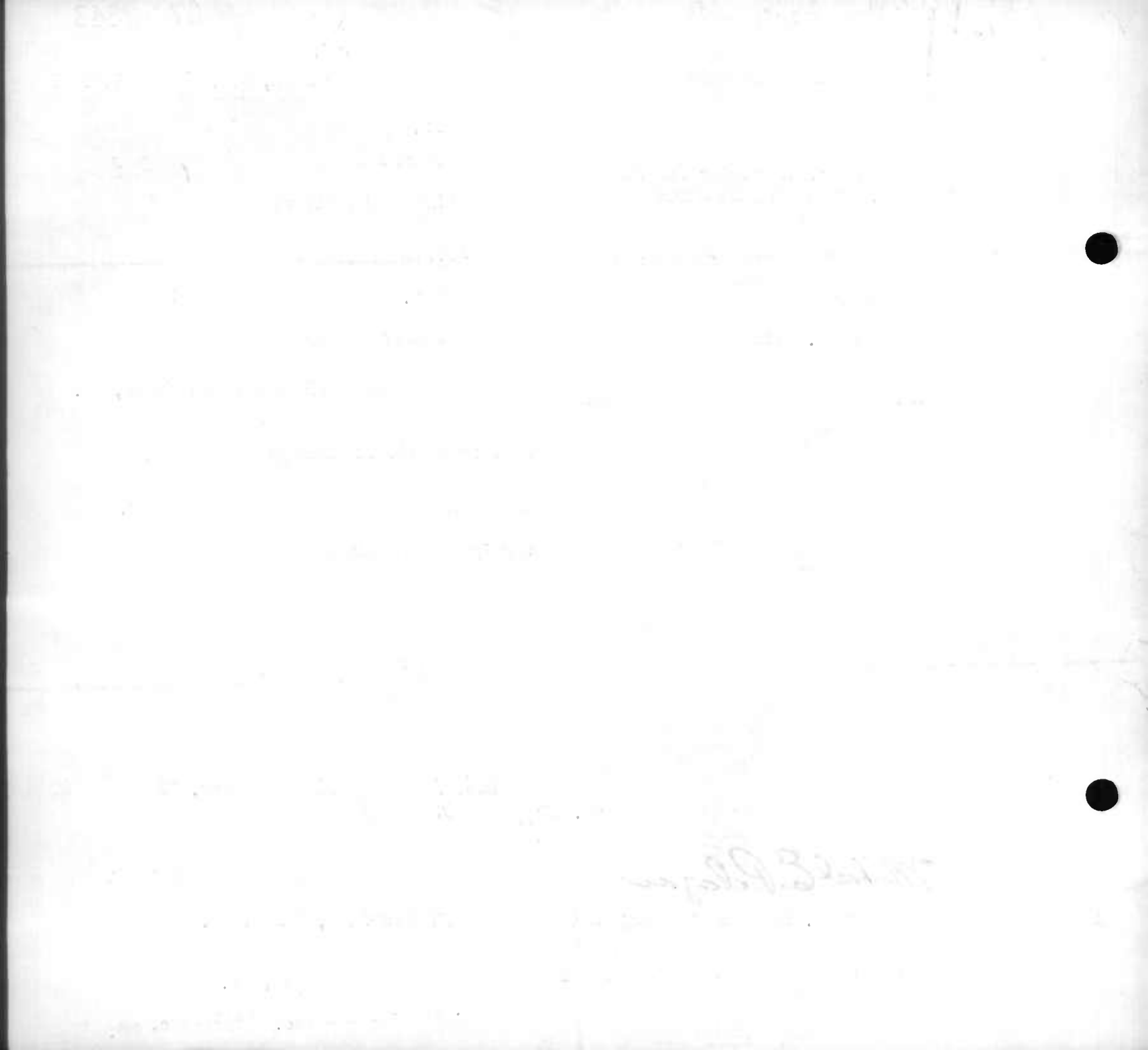


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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Pa 67 2843		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2843	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Patricia Ann Weis			2. DATE AND HOUR OF DEATH March 21, 1967 9:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Columbia D. STREET ADDRESS (If rural, give location) 719 Walnut Street		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Child	8. DATE OF BIRTH 12/3/61	9. AGE (In years lost birthday) 5	If Under 1 Yr. Months If Under 24 Hrs. Oays Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME August G. Weis			14. MOTHER'S MAIDEN NAME Joline Wolpert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. CAUSE OF DEATH 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Gastrointestinal hemorrhage (A) DUE TO Pancytopenia (B) DUE TO Acute lymphatic leukemia (C) INTERVAL BETWEEN ONSET AND DEATH Days Mos. Mos.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from Dec. 5, 1966 to Mar. 21, 1967, that (X) (we) last saw the deceased alive on Mar. 21, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelczar M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/22/67	
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surgeon (R) M.O.				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/67		24C. NAME OF CEMETERY or CREMATORY Holy Trinity	
24D. LOCATION Columbia, Pa.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Salky		25C. FUNERAL DIRECTOR Wm. Cook & Brooks Inc. Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2844	
BIRTH NO. 67 2844		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Solomon Felleman		2. DATE AND HOUR OF DEATH 3-21-67 6:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Baltimore			
90 House in the Pines Belvedere		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lutherville 21093			
		D. STREET ADDRESS (If rural, give location) 1212 Malbay Drive 53-00			
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Feb. 1, 1882	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Clothing Store		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Levy Felleman		14. MOTHER'S MAIDEN NAME Hannah Baer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 102009-3220A		17. INFORMANT Jennie F. Schott Same as # 4	
18. 3-21-XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 days unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 2-18-1965 to 3-21-1967, the (1) (we) last saw the deceased alive on 3-20-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David I. Miller M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-21-67			
23C. PHYSICIAN'S NAME (Type) David I. Miller M.D.		23D. ADDRESS Linson Rd - Owings Mills, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-1967		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery	
				24D. LOCATION Brooklyn, New York	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Md.	

At this address
Central Market Street

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2845	
BIRTH NO. 67 2845		CERTIFICATE OF DEATH		Registered No. 67 2845	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY E. Wiese		2. DATE AND HOUR OF DEATH 9-21-67 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-02	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green N. H		D. STREET ADDRESS (If rural, give location) 3506 Howard PK Ave			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-31-1883	9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dixon, Missouri	
13. FATHER'S NAME Thomas Todd		14. MOTHER'S MAIDEN NAME Mary Bull		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-01-5728		17. INFORMANT ADDRESS Bernice Wiese - 4 East 32nd Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Coronary Occlusion DUE TO (B) Ca. of Liver DUE TO (C) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 Mos - 3 Mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-22-67 to 3-19-67, that (I) (we) last saw the deceased alive on 3-19-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Thomas G. Abbott		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Thomas G. Abbott		M.D. 23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Ellsworth Armacost	
				ADDRESS Ellsworth Armacost - 4600 Liberty Hgts.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2846		CERTIFICATE OF DEATH		67 2846	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Herbert N. Strawbridge		2. DATE AND HOUR OF DEATH March 21, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 4400 Fernhill Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4400 Fernhill Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-6-1885	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stockbroker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) York, Pennsylvania	
13. FATHER'S NAME Robert B. Strawbridge		14. MOTHER'S MAIDEN NAME Alice M. Smith		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-01-6723		17. INFORMANT ADDRESS Herbert N. Strawbridge, Jr. 4400 Fernhill Ave.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Coronary arterial infarction DUE TO (B) Generalized arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to present , that (I) (we) lost saw the deceased alive on 3/1 1967 and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-1967		24C. NAME of CEMETERY or CREMATORY Lorraine Mausoleum	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature] ADDRESS Ellsworth Armacost - 4600 Liberty Hgts.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 123-46-82	
BIRTH NO. 67 2847		CERTIFICATE OF DEATH		123-46-82	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Allen, Nora		2. DATE AND HOUR OF DEATH 3/21/67 5:36 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		A. STATE B. COUNTY Baltimore Maryland		C. CITY OR TOWN Baltimore 8-06	
D. STREET ADDRESS (If rural, give location) 1730 N. Washington Street		5. SEX F		6. RACE C	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) separated		8. DATE OF BIRTH 1-31-25		9. AGE (In years last birthday) 42	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Reidsville N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Steve Lee		14. MOTHER'S MAIDEN NAME IDA WASHINGTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 246-22-9030		17. INFORMANT ADDRESS Mae Lois Hollis-1730 N. Washington St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Rheumatic anti-bruising		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3/2/67 to 3/11 1967, that (we) lost saw the deceased alive on 3/11 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Katz		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type) M. KATZ		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/67		24C. NAME OF CEMETERY or CREMATORY Mt. Herman Cemetery	
24D. LOCATION (City, town, or county) Ruffin North Carolina					
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Ave.	



W-460

BIRTH NO. 67 2848		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2848	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		FLORENCE WEILLER		3-21-67 6:10 PM _{M.}	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
2525 EUTAW PLACE - Apt. 4-C		Baltimore		13-01	
D. STREET ADDRESS (If rural, give location)		2525 Eutaw Place - Apt.-4-C		21217	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Widowed	March 27, 1884	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		Samuel Frank		Rebecca ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No None				Mr. Sol Goodman 6410 Cross Country Blvd.	
18. 422.1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		RUSSELL S. FISHER, M.D.		3/23/1967	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county)		1State	
Baltimore Hebrew Cemetery		Baltimore, Md.			
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAR 23 1967		Robert E. Fisher, M.D.		Wm. F. Zimmerman 2 Sons North Ave. Balto., Md.	

BALTIMORE CITY HEALTH DEPARTMENT

67 2849

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. _____

1
67 2849
BIRTH NO.
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Leonetta M. McGill		2. DATE AND HOUR PRONOUNCED DEAD 3-20-67 4:25 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 2406 ALLENDALE ROAD - Sgt. Robert Butts DOA		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2406 Allendale Road 21216	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 7, 1890
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Schreyer		14. MOTHER'S MAIDEN NAME Mary Magdaleua	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. William McGill		ADDRESS 237 President St.	

18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 3-23-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		M.D. Werner U. Spitz		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-21-67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/23/1967		23C. NAME of CEMETERY or CREMATORY Western Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	

24A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Wm. J. Thibault & Sons		ADDRESS Baltimore, Md.	
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 2850					67 2850				
BIRTH NO.					REGISTERED NO.				
1. NAME OF DECEASED (Type or Print) <u>Thomas Bernard Sheridan</u>					2. DATE AND HOUR OF DEATH <u>MARCH 22, 1967 11:30 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>					A. STATE <u>MARYLAND</u>				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 10, 12-01</u>				
					D. STREET ADDRESS (If rural, give location) <u>116 W. University Parkway</u>				
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>05-29-86</u>	9. AGE (In years lost birthday) <u>80</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXECUTIVE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AMER. BANK STATIONARY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Frank Sheridan</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>THOMAS M. SHERIDAN (Grandson)</u>		ADDRESS <u>MONKTON, MD</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>422.1 I</u> <u>Bronchial Pneumonia</u>					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cong. Heart Failure</u>					(B) DUE TO		<u>3 days</u>		
					(C) <u>ABCD</u>		<u>? Years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 22, 1967</u> to <u>MARCH 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 22, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>James W. Carty, Jr.</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/22/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>JAMES W. CARTY, JR.</u>					23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/27/1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR <u>Wm. J. Fisher & Sons with L.P.H.</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						BIRTH NO. 67 2851		Registered No. 67 2851	
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) DONALD WALLS						2. DATE AND HOUR OF DEATH 3/21/67 12⁰⁰ Subst.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTD.						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-15 D. STREET ADDRESS (If rural, give location) 4400 FALLS ROAD.			
5. SEX M	6. RACE N	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)		8. DATE OF BIRTH 12-12-33	9. AGE (In years lost birthday) 33	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MECHANIC			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME WM. WALLS				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT BETTY J. WELLS-4400 FALL ROAD		ADDRESS			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest 2nd to Angina DUE TO Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. —						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3/20 9³⁰ PM 19 67 to 3/21 12^{midst} 19 67 , that (I) (we) last saw the deceased alive on 3/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E.B. Samson - Corvera				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/21/67			
23C. PHYSICIAN'S NAME (Type) E. B. SAMSON - CORVERA				M.D. Sinai Hosp. of Balto		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Windsor Mill Rd, Md			
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Austin E. Donovan		ADDRESS 3818 Roland Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2852	
BIRTH NO. 67 2852 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) RUTH PRUNTY		2. DATE AND HOUR OF DEATH 3-31-67 6:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-06 D. STREET ADDRESS (If rural, give location) 3621 FALLS ROAD		
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH MAY 27, 1921	9. AGE (In years lost birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) W. VIRGINIA	
13. FATHER'S NAME ADA ANDERSON SMALL			14. MOTHER'S MAIDEN NAME AUDREY MAY LONGINETTE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS GLADYS SARACIN, 3647 KEYSTONE AVE	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 581.11 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH 1 day </div> </div> <div style="margin-top: 10px;"> (A) DUE TO HEPATIC COMA (B) DUE TO LAENNAEC'S CIRRHOSIS (C) DUE TO --- </div>					
19A. DATE OF OPERATION ---		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that the (this hospital) attended the deceased from 9-30 19 67 to 3-31 19 67 , that (I) (we) last saw the deceased alive on 3-31 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Judith Dodrill Gardner M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3-31-67	
23C. PHYSICIAN'S NAME (Type) JUDITH DODRILL GARDNER				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/67		24C. NAME of CEMETERY or CREMATORY Lake View Memorial Park Liberty Rd, Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Austin C. Donovan - 3818 Roland Ave.	

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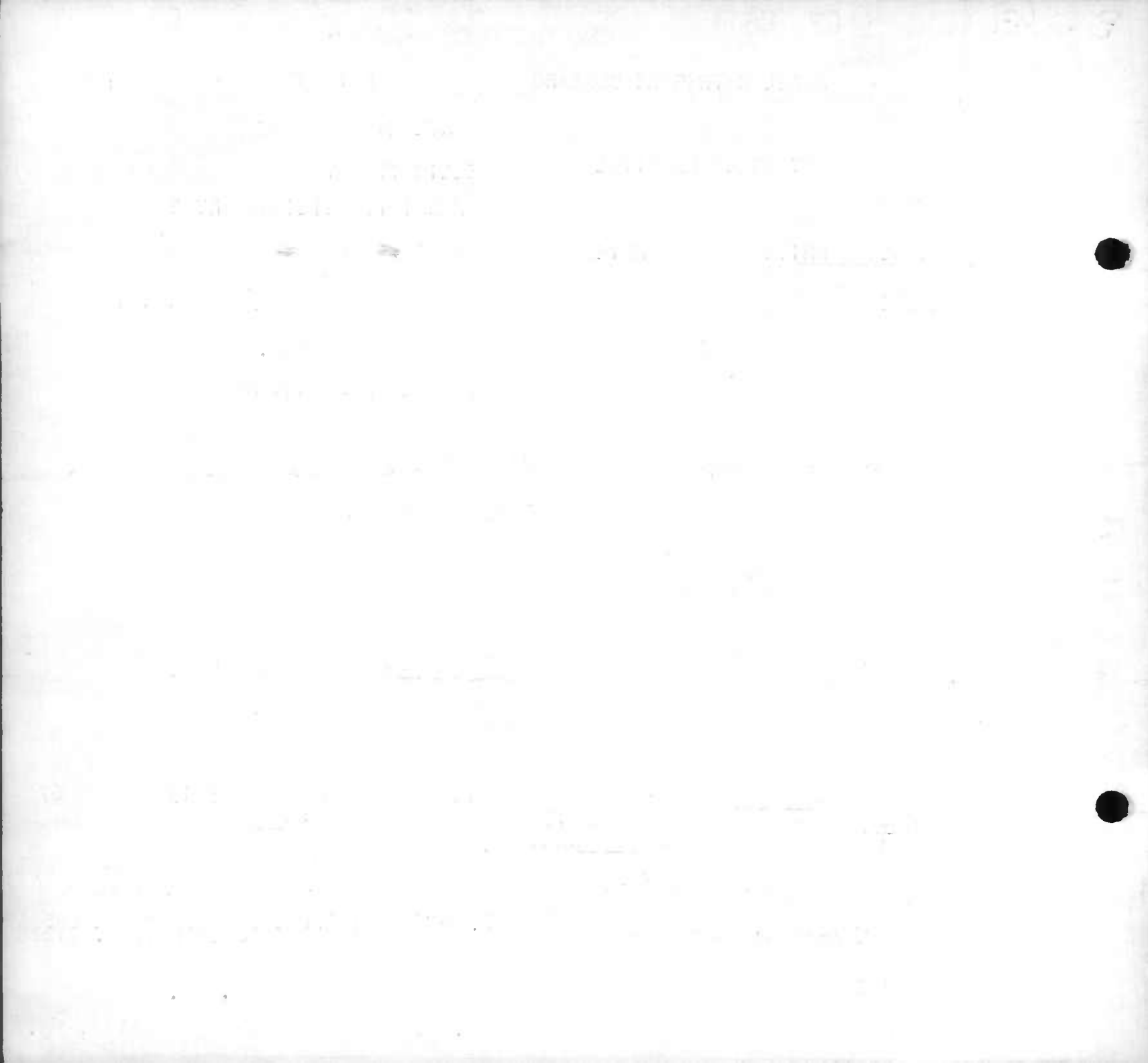
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2853		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2853	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
HAZEL KATHERINE BUSSARD		3 19 67		8:30A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			A. STATE B. COUNTY MARYLAND Howard G		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY 63-00		
D. STREET ADDRESS (If rural, give location) MARRIOTTSSVEILE RD RT 2			5. SEX 6. RACE 7. MARRIED, NEVER MARRIED FEMALE WHITE WIDOWED, DIVORCED (specify) MARRIED		
8. DATE OF BIRTH 9. AGE (In years lost birthday) 58			10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWFE		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) W VA		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Stultz		
14. MOTHER'S MAIDEN NAME Lottie L.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT ST AGNES HOSP RECORDS		
18. 493 X1 CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO MENINGITIS (B) DUE TO PNEUMONIA (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 3 19 67 to 3 19 67, that (X) (we) last saw the deceased alive on 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JUAN J. CABRERA				23B. DATE SIGNED 3/19/67	
23C. PHYSICIAN'S NAME (Type) JUAN J. CABRERA				23D. ADDRESS ST. AGNES HOSPITAL, CATON & WILKENS AV, BALTIMORE, MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/1967		24C. NAME of CEMETERY or CREMATORY Bethesda Cemetery	
24D. LOCATION Carroll Co, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967			
25B. NAME OF REGISTRAR Robert E. Salzman		25C. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2854	
BIRTH NO. 67 2854		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Richard Anton Faber</i>		2. DATE AND HOUR OF DEATH <i>March 19, 1967</i> 3P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 House in the Pines-Belvedere</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> 27-48			
		D. STREET ADDRESS (If rural, give location) <i>1004 Woodson Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>March 27, 1895</i>	9. AGE (In years lost birthday) <i>71</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Investigator-Auditor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Glens Falls Ins. Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>Otto Faber</i>		14. MOTHER'S MAIDEN NAME <i>Emilie Sommers</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-03-5443</i>		17. INFORMANT <i>Gertrude M. Faber</i>	
				ADDRESS <i>1004 Woodson Road-21212</i>	
18. <i>332X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral Thromboses</i> DUE TO <i>Generalized arteriosclerosis</i> (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1-11/2</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 16</i> 19 <i>67</i> to <i>Mar 19</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Mar 19</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lester N. Kolman</i>				23B. DATE SIGNED <i>3-22-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Lester N. Kolman, M.D.</i>				23D. ADDRESS <i>3700 Park Heights Ave. 21215</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/22/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John C. Mibler Inc</i>	
				ADDRESS <i>415 Belair Road-21206</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2855		Registered No. 67 2855	
CERTIFICATE OF DEATH				MABEL BAILEY (B)		3-21-67 2:45 P.M.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND			
5. SEX FEMALE				6. RACE NEGRO			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED				8. DATE OF BIRTH 2-28-30		9. AGE (In years lost birthday) 37	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic						12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JAMES STARK				14. MOTHER'S MAIDEN NAME MAMIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital chart	
18. 330X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Subarachnoid Hemorrhage (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/20 19 67 to 3/21 19 67, that (1) (we) last saw the deceased alive on 3/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Rampton				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type) R. RAMPTON				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR 1206 W North Ave		ADDRESS V	

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67 2856

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2856

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William F. Bueke

2. DATE AND HOUR PRONOUNCED DEAD

3-18-67

1:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2402 N. Calvert St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2402 N. Calvert St

5. SEX

M

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
single

8. DATE OF BIRTH

8-3-1895

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Social Sec. Adm.

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

??

14. MOTHER'S MAIDEN NAME

?????

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

yes

WW I

16. SOCIAL
SECURITY NO.

124-05-3261

17. INFORMANT

ADDRESS

21213

Alfred L. Christian, 2103 Belair Rd., Balto

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner L. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-19-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-24-67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Catonsville, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 23 1967

Wm. Cook-Brooks, Inc. Balto., Md.

MAINTENANCE OF RECORDS

TAKS

2007 1000000

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2857

1. NAME OF DECEASED
(Type or Print)

SYLVIA JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

3-22-67

3:00 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

42 SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3714 Reisterstown Road 21215

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9-16-1940

9. AGE (In years
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SEAMRESS

10B. KIND OF BUSINESS OR INDUSTRY

FACTORY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS SAMPSON

14. MOTHER'S MAIDEN NAME

BERNICE BRADLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Bernice Brooks 3804 Park Hgts. Av

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Spontaneous pneumothorax
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Chronic bronchitis with emphysema
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-22-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-25-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 23 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

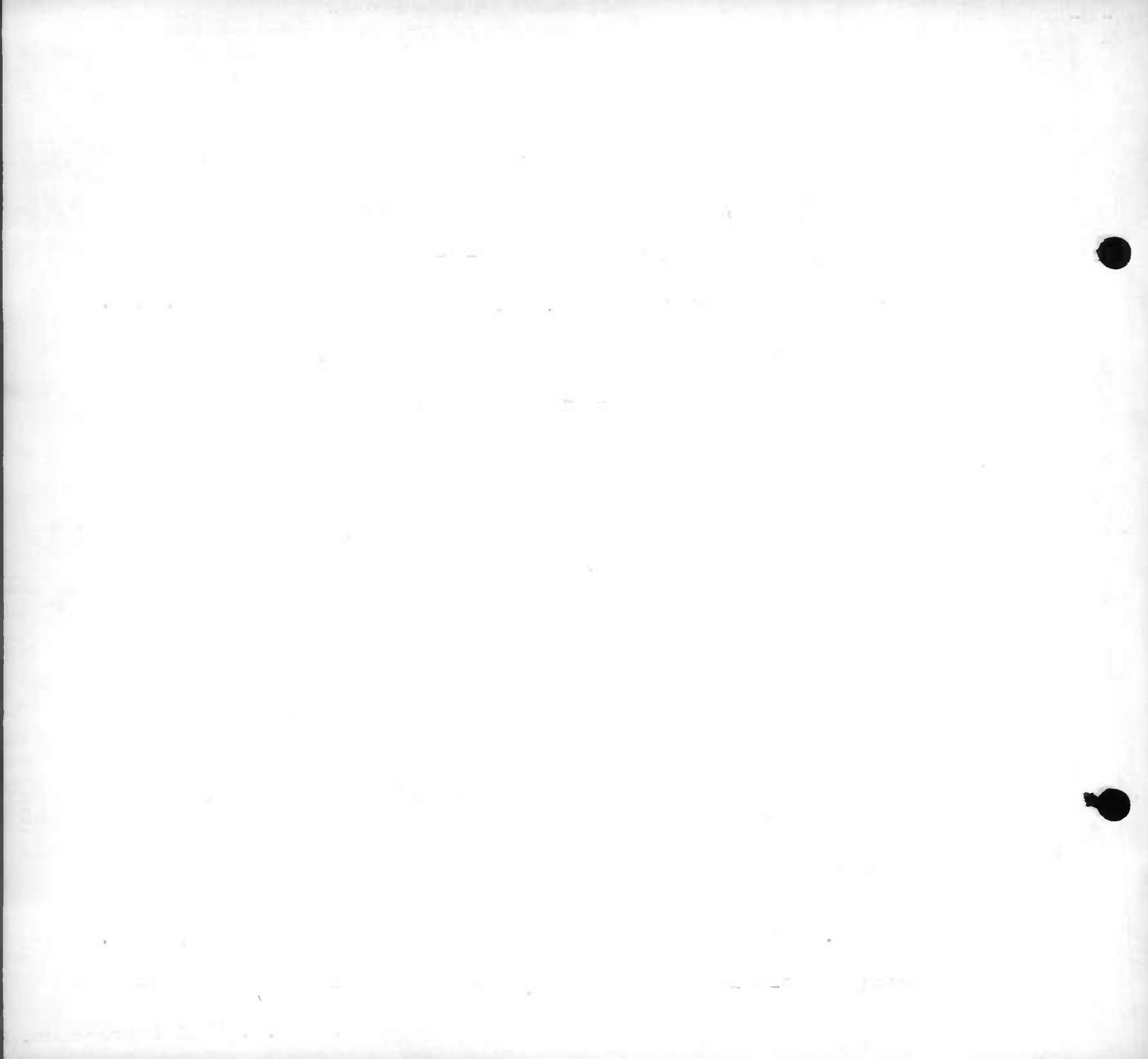
ADDRESS

1701 Laurens St

WALLACE FORDE
220/221 SWIFT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2858	
BIRTH NO. 19-652 67 2858		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GRANGER HURIE		2. DATE AND HOUR OF DEATH 3/22/67 7:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2405 Baker Street 21216			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-29-84	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Mathison Chem. Co. Alabama		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Wesley Granger		14. MOTHER'S MAIDEN NAME Amanda (Hoffman)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-7942		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO ASCVD		year	
		(B) DUE TO probable pneumonia		hours	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/20 1966 to 3/22 1967, that (I) (we) last saw the deceased alive on 3/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Swimmer M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/22/67			
23C. PHYSICIAN'S NAME (Type) Dr. David Swimmer		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2859	
BIRTH NO. 67 2859		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH March 22, 1967	
1. NAME OF DECEASED (Type or Print) John Forcey		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial		A. STATE MD B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 609 Willow Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH Mar 1 - 1917
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY Janitor supply	9. AGE (In years last birthday) 50
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Forcey		14. MOTHER'S MAIDEN NAME Ida Banell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Ms Susie Startevant
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Atherosclerotic Cardiovascular disease 2 months		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) 4 DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Feb 2, 1967 to Mar 9, 1967 , that (1) (we) lost saw the deceased alive on Mar 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Lee V. Chandler		23B. DATE SIGNED March 22, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
M.D.		M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-27-67	24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.	24D. LOCATION (City, town, or county) (State) A.A. Co. Md.
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967	25B. NAME OF REGISTRAR Robert E. Johnson	25C. FUNERAL DIRECTOR Horst & Dyett F.H.	ADDRESS 1701 Laurens St



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-082292880		BALTIMORE CITY HEALTH DEPARTMENT		34-47-29		Registered No. M 67 2880	
1. NAME OF DECEASED (Type or Print) Joseph A. Carter				2. DATE AND HOUR OF DEATH 3/19/67 9⁴⁵ P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 423 N. Carrollton Ave			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) —	8. DATE OF BIRTH 1/7/67	9. AGE (In years last birthday) 2	10. MONTHS 12	11. DAYS 12	12. HOURS 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lenwood Medley				14. MOTHER'S MAIDEN NAME Mac Carter Same			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Hosp. chart		ADDRESS	
18. 491X I		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Aspiration pneumonia				20 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) —					
		(C) —					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 19 1967 to March 19 1967 , that (I) (we) last saw the deceased alive on March 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Franklin Johnson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type)		M.D. University Hosp		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Mt. W. inas	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Joseph R. Russ		25C. FUNERAL DIRECTOR Joseph R. Russ		ADDRESS 372 N. Carrollton Ave. Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2861		CERTIFICATE OF DEATH		Registered No. 67 2861	
1. NAME OF DECEASED (Type or Print) Laura P. Cook				2. DATE AND HOUR OF DEATH March 17, 1967 9⁴⁰ P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4006 Kathland Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-10 D. STREET ADDRESS (If rural, give location) 4006 Kathland Avenue					
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Sept. 6, 1885	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Stephen Quarles				14. MOTHER'S MAIDEN NAME Laura ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-63-9275		17. INFORMANT Mrs. Laura Phillips		ADDRESS 4006 Kathland Ave.			
18. H20,041260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO SENILITY					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 2/23 19 56 to 3/17 19 67 , that (I) (we) last saw the deceased alive on 3/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Gilbert L. Banfield				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/20/67			
23C. PHYSICIAN'S NAME (Type) GILBERT L. BANFIELD		M.D.		23D. ADDRESS 722 N. Fattory Ave Balt. Md.					
24A. BURIAL CREMATION, REMOVAL (specify) Burial		24B. DATE 3/21/67		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus (Baltimore) Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR J. E. F. J. J.		25C. FUNERAL DIRECTOR Joseph L. Rues		ADDRESS 2222 N. Market Ave. Baltimore, Md.			

10th Nov 1943

Dear General

I am

very pleased to hear

from you and

hope you are

well.

With best wishes

Yours faithfully

John G. ...

...

Yours sincerely

...

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 67 2862	
BIRTH NO. 400 67 2862		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Verena Riley			2. DATE AND HOUR OF DEATH 9:30 AM 3/21/67 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 8-04 D. STREET ADDRESS (If rural, give location) 2102 East Hoffman Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/27/07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Abhyville, S. Carolina	
13. FATHER'S NAME West Davis			14. MOTHER'S MAIDEN NAME Lillie Davis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Prince Riley 601 Jenkins St. Brunswick, S.C.	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Artemia (B) DUE TO H. B. D. (C) Diphtheria		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/17 19 67 to 3/21 19 67 , that (I) (we) last saw the deceased alive on 3/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Ismail Belg			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Physician <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/21/67
23C. PHYSICIAN'S NAME (Type) F. Ismail Belg			23D. ADDRESS M.D. The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/24/67	24C. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		24D. LOCATION (City, town, or county) (State) Brownsville, S. Carolina	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 23 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Joseph L. Rues	
				ADDRESS 2222 W. North Ave. Baltimore, Md.	

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to file

Handwritten signature

MR. GREGORY, MEDICAL INVESTIGATOR NOTIFIED
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2863		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2863	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MRS. MATTIE E. CLARK		2. DATE AND HOUR OF DEATH 3-22-67 3:22 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL BALTO, MD. 21231		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5-01 D. STREET ADDRESS (If rural, give location) 1105 E. FAYETTE ST.			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)	8. DATE OF BIRTH 3/18/85 AGE (In years and birthday) 81 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME NA THANIAL FUNKHOUSER		14. MOTHER'S MAIDEN NAME REBECCA SAUM		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-70-9722		17. INFORMANT SON ORDON BEVANS ADDRESS NELSON Mill ROCKS, MD.	
18. 420.14 IE900.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. INTERTRAUMATIC fracture of Right Femur.		CAUSE OF DEATH (A) DUE TO Acute myocardial infarction (B) DUE TO Atherosclerotic Heart disease years (C) INTERTRAUMATIC fracture of Right Femur.		INTERVAL BETWEEN ONSET AND DEATH Seconds	
19A. DATE OF OPERATION NO DATE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO DATE		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) FAYETTE NURSING HOME, 1105 E. FAYETTE ST.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) MARCH-12-67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL DOWN STEPS	
22. I certify that (I) (this hospital) attended the deceased from 3-19-1967 to 3-22-1967, that (I) (we) last saw the deceased alive on 3-22-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel J. Tan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-22-67	
23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN		23D. ADDRESS CHURCH HOME + HOSPITAL BALTO, MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/25/67		24C. NAME OF CEMETERY or CREMATORY Parkwood CEMETERY	
24D. LOCATION BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 23 1967			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
25E. DATE REC'D BY HEALTH DEPT. MAR 23 1967		25F. NAME OF REGISTRAR		25G. FUNERAL DIRECTOR	
25H. ADDRESS		25I. ADDRESS			

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CERTIFICATE OF DEATH

Registered No. 67 2864

BIRTH NO. 67 2864

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Thomas J. Williams

2. DATE AND HOUR OF DEATH

3/20/67.

11:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31 Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1000.

1-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3048

O'Donnell St.

21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

3-28-80

9. AGE (In
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

ROBERTS PACKING CO.
Cannery

11. BIRTHPLACE (State or foreign country)

OKLAHOMA

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Sam WILLIAMS

14. MOTHER'S MAIDEN NAME

Ellen Hoak

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

yes

'05 - '06 USN.

16. SOCIAL
SECURITY NO.

220-01-3003A

17. INFORMANT

4940 Eastern Ave. Baltimore, Md.
David P. Curtis, Jr. M.D.

ADDRESS

GCH.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

pulmonary tuberculosis

INTERVAL BETWEEN
ONSET AND DEATH

1 yr

(B) DUE TO

chronic obstructive lung disease 10 yrs -

(C) DUE TO

(?) pulmonary embolus

10 minutes

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Extreme emaciation

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1/19 1967 to 3/20 1967,
that (I) last saw the deceased alive on 3/20 1967 and that in (my) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

David P. Curtis, Jr.

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/20/67

23C. PHYSICIAN'S
NAME (Type)

David P. Curtis, Jr.

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.
Baltimore City Hospital.24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

3-23-67.

24C. NAME of CEMETERY or CREMATORY

MT. CARMEL CEM.

24D. LOCATION

5712 O'DONNELL ST. BALTO., MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 23 1967

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

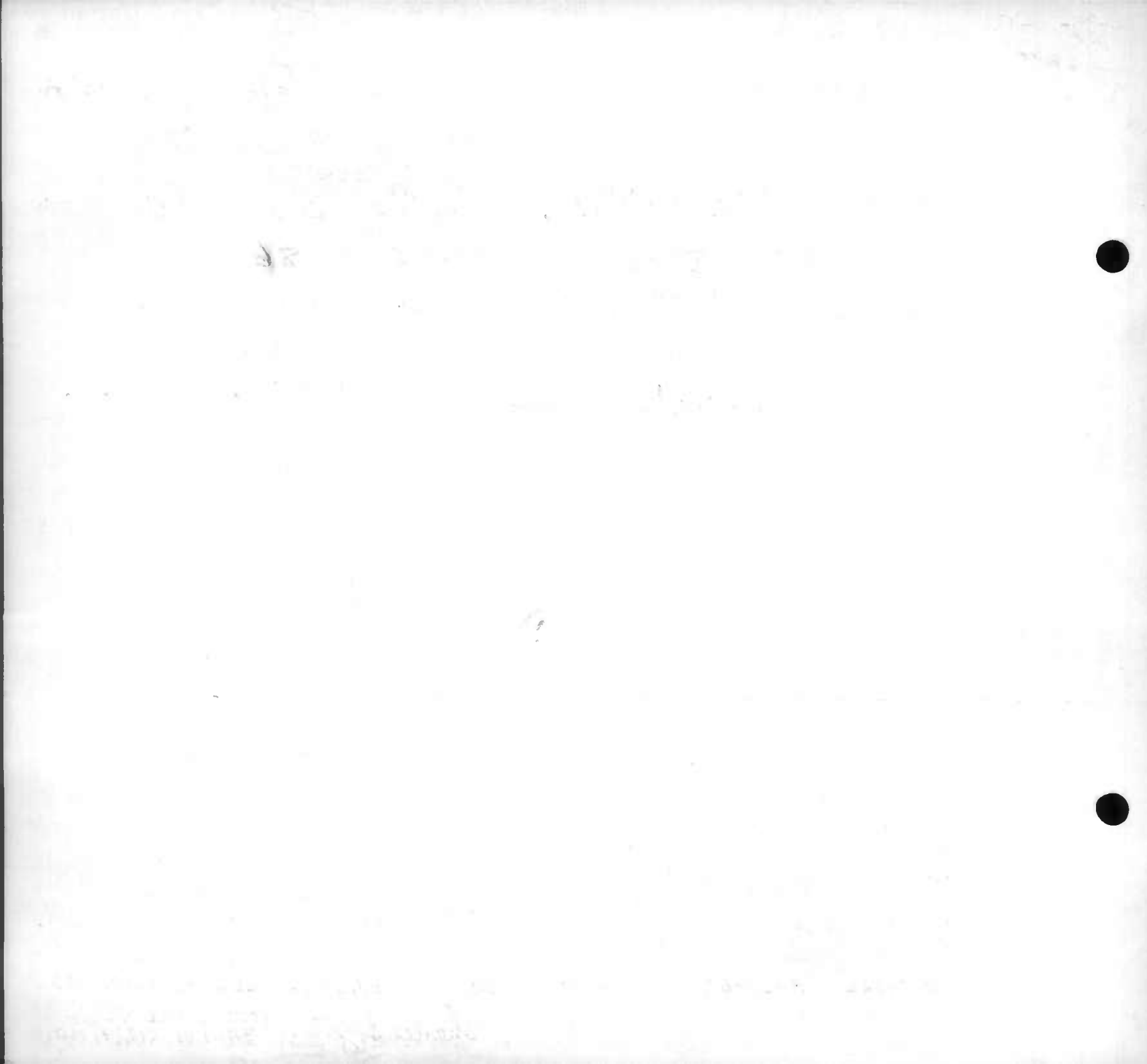
Charles L. Zeiler

ADDRESS

901 S. CONKLING ST.
BALTO., 21224, MD.

FUNERAL DIRECTOR: IMPORTANT

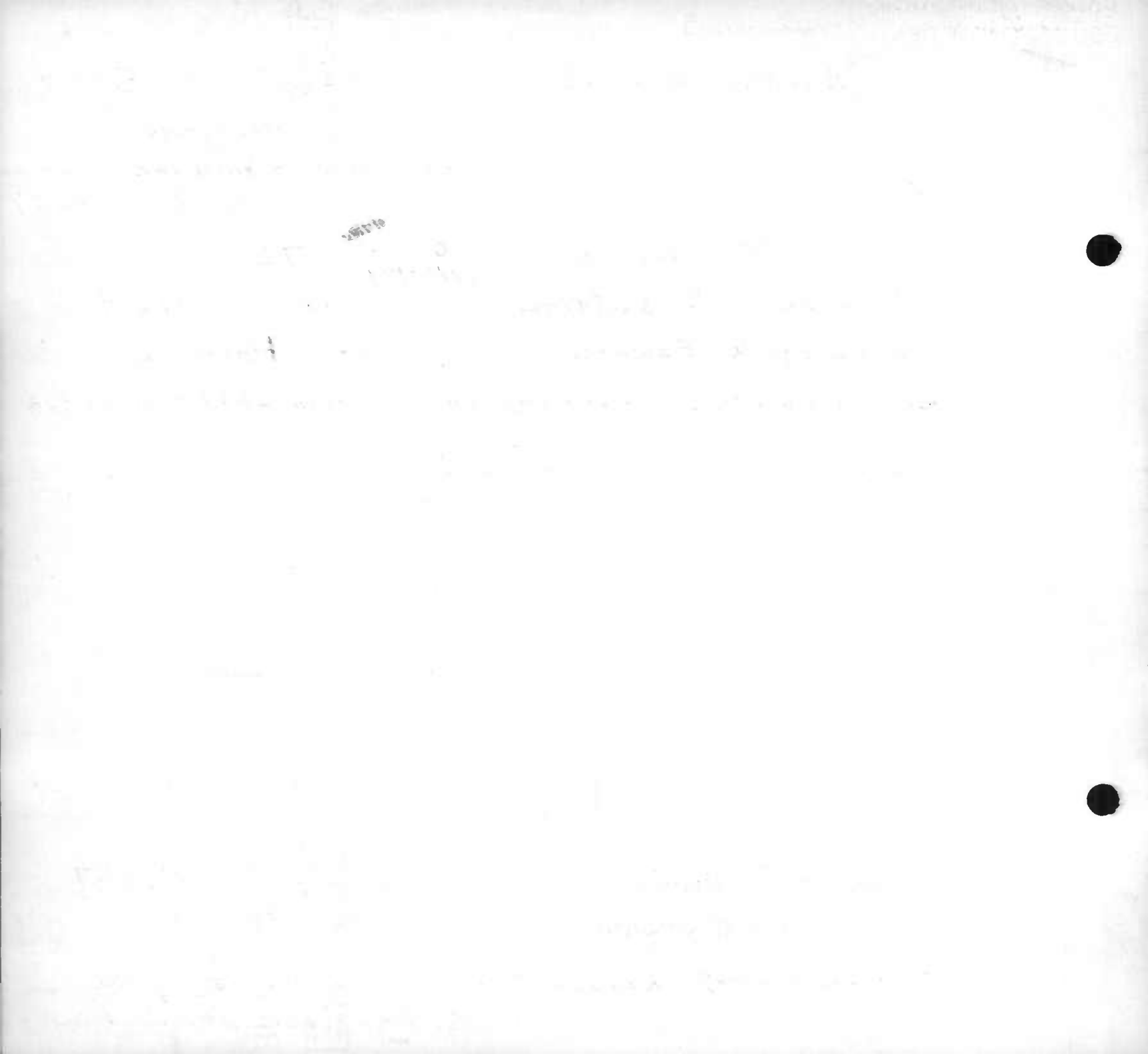
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2865		CERTIFICATE OF DEATH		67 2865	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM D. EDWARDS		2. DATE AND HOUR OF DEATH 3/25/67 5 05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE Highlands 53-00 D. STREET ADDRESS (If rural, give location) 2828 Florida Ave 21227			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10/08/94	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Industrial		11. BIRTHPLACE (If foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William W. Edwards			14. MOTHER'S MAIDEN NAME MARTHA HARWOOD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES - WORLD WAR I		16. SOCIAL SECURITY NO. 216-03-2949		17. INFORMANT WM. H. EDWARDS ADDRESS 2828 Florida Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IRREVERSIBLE SHOCK DUE TO ACUTE MYOCARDIAL INFARCTION (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/15 1967 to 3/25 1967 , that (I) (we) lost saw the deceased alive on 3/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar E. Fernandini M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3/25/67	
23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI M.D.				23D. ADDRESS LUTHERAN HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-29-67		24C. NAME OF CEMETERY or CREMATORY London Park	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR Robert E. Jackson, M.D.		25C. FUNERAL HOME ADDRESS Ed. L. Sawab Funeral Home 2101 Frederick Ave.			



W-452

67 2886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 2886

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John D. Williams.

2. DATE AND HOUR OF DEATH

3-22-1967 7:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

43

South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Harford Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Bel Air

62-00

D. STREET ADDRESS (If rural, give location)

Box #158 Rt. #1

5. SEX

M.

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

1-20-1883

9. AGE (In years
last birthday)

84

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Coal Miner, & Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Coal Mines, & Farm

11. BIRTHPLACE (State or foreign country)

TENN.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Cameron Williams (D)

14. MOTHER'S MAIDEN NAME

Matilda Hopper (D)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

401-18-5420

17. INFORMANT

ADDRESS

Ppsey DeHart, Bel Air, Maryland

18. 722.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

CUA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

ASCVDy

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No.

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 3-21 1967 to 3-22 1967.
that (we) last saw the deceased alive on 3-22 1967 and that in (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard H. Reed

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3-22-67

23C. PHYSICIAN'S
NAME (Type)

Richard H. Reed

M.D.

23D. ADDRESS

1213 Light St. Balto., Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

24-Mar-67

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAR 27 1967

25B. NAME OF REGISTRAR

R. E. Farley

25C. FUNERAL DIRECTOR

H. W. Cochran Jr.

Farring Funeral Home

Aberdeen, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48

Little, the creator of

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2867		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2867	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) Roussey Juanita Ruth	
2. DATE AND HOUR OF DEATH		MARCH 21, 1967 6:20 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL		A. STATE MD. B. COUNTY ABERDEEN Harford Co.			
5. SEX F		6. RACE W		7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify))	
8. DATE OF BIRTH 6-18-22		9. AGE (In years last birthday) 44		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Harford Eng. Co.		11. BIRTHPLACE (State or foreign country) Tazewell, Virginia	
13. FATHER'S NAME LUTHER NECESSARY		14. MOTHER'S MAIDEN NAME MAUDE ASHLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 283-16-4778		17. INFORMANT ADDRESS 430 Bernice Terrace George A. Roussey, Aberdeen, Maryland	
18. 470X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Calific Aortic Stenosis, Aortic Stenosis & Insufficiency during surgical replacement of (Rheumatic Heart disease)		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		MEDICAL CERTIFICATION			
19A. DATE OF OPERATION 3/21/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Stenosis & Insufficiency		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/17/67 to 3/21/67 that (I) (we) last saw the deceased alive on 3/21/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. N. Irani		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type) DR B. N. IRANI		23D. ADDRESS University Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 25 Mar. 67		24C. NAME OF CEMETERY or CREMATORY Bakers Cemetery	
24D. LOCATION (City, town, or county) (State) Aberdeen Harford Co. Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR R. E. F. Adams		25C. FUNERAL DIRECTOR Tarring Funeral Home			
25D. ADDRESS Dr. Aberdeen, Md.					

31

Walter D. Mignolo

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 67 2868					
BIRTH NO. 67 2868		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) DOYLE, MARY CATHERINE			2. DATE AND HOUR OF DEATH MARCH 22, 1967 9:00 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE MD. 21229					A. STATE MARYLAND B. COUNTY 21229					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
D. STREET ADDRESS (If rural, give location) 4730 FREDERICK AVE.					25-04					
5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED										
8. DATE OF BIRTH 1-31-89			9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JOHN BUTLER DEC'D					14. MOTHER'S MAIDEN NAME CATHERINE (CUNNINGHAM) DEC'D					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS John B. Doyle - 4730 Frederick Ave					
18. 2002 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Malignant lymphoma					INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 2, 19 67 to MARCH 22, 19 67 . that (X) (we) last saw the deceased alive on MARCH 22, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Pabelo E. Dibos					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 3/23/67		
23C. PHYSICIAN'S NAME (Type) PABELO E. DIBOS					23D. ADDRESS M.D. ST. AGNES HOSPITAL - CATON & WILKENS AVE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-67		24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			25B. NAME OF REGISTRAR R. E. Farley			25C. FUNERAL DIRECTOR ADDRESS Gulley-Corning Bldg Catonsville Md.				

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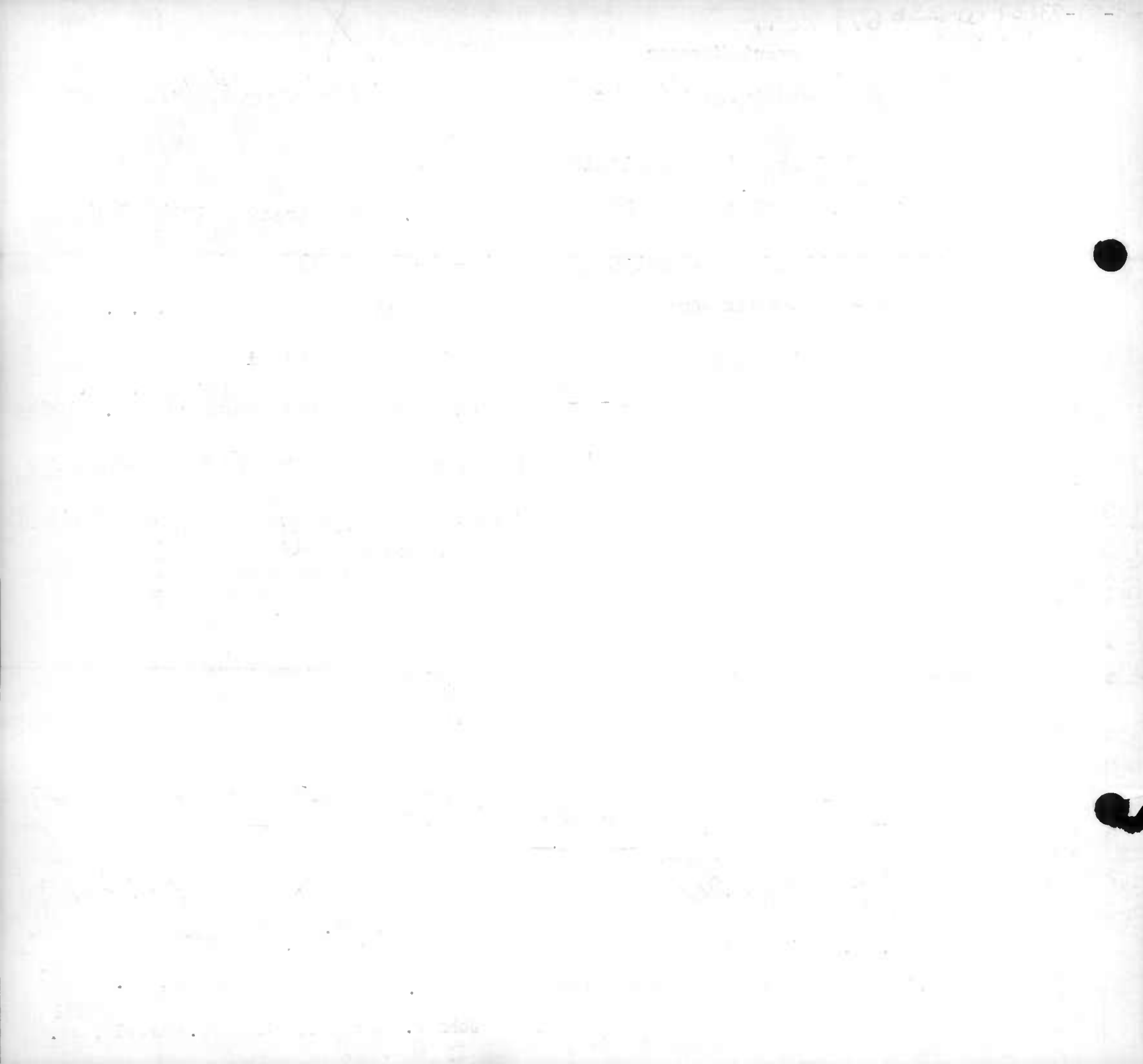
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-256 67 2869		CERTIFICATE OF DEATH		Registered No. 67 2869	
M.E. CASE NO. Leonard Wiessner		1. NAME OF DECEASED (Type or Print) Wiessner, Leonard		2. DATE AND HOUR OF DEATH March 24 1967 11 40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 528 S. 45th Street 21224 005			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-19-93	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Maintenance Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bernard Wiessner		14. MOTHER'S MAIDEN NAME Elizabeth Kaminski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-5738		17. INFORMANT BCH:Records ADDRESS Baltimore, Md. 4940 Eastern Ave. #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus		CAUSE OF DEATH (A) DUE TO Chronic Lung Disease		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		20 yrs.	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3-23 1967 to 3-24 1967 , that (I) last saw the deceased alive on 3-24 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE A. P. Weinfeld				23B. DATE SIGNED 3-24-67	
23C. PHYSICIAN'S NAME (Type) A. P. Weinfeld		23D. ADDRESS Baltimore, Md. 4940 Eastern Ave. # 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/67		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2870		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2870	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. MARY BOCKLAGE		2. DATE AND HOUR OF DEATH 3/24/67 9:37 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSP		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 815 S. LINWOOD AVE. (24)			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH May-3-1883	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? AMERICA
13. FATHER'S NAME WILLIAM MURPHY		14. MOTHER'S MAIDEN NAME MARY HOWARD		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-48-2812		17. INFORMANT CHURCH HOME & HOSP.		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema Coronary Insufficiency + arteriosclerotic heart disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH one day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX) 3-24 1967		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-23 1967 to 3-24 1967 , that (I) (we) last saw the deceased alive on 3-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Asst. Dir.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-24-67	
23C. PHYSICIAN'S NAME (Type) Dr. J. Martinez		23D. ADDRESS CH & A.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-1967		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR R. E. E. Taylor, Md.		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, Baltimore, Md. 21224			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2871	
BIRTH NO. 67 2871		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GORDON, JAMES, M.		2. DATE AND HOUR OF DEATH 3-18-1967 10:10PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND 46		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE 20-02 D. STREET ADDRESS (If rural, give location) 2715 LAURETTA AVE			
5. SEX M	6. RACE C	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (Specify) NEVER MARRIED	B. DATE OF BIRTH 2-28-10	9. AGE (In years last birthday) 57	11. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Car.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME James R. Gordon		14. MOTHER'S MAIDEN NAME Mary Harrison	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-01-9430		17. INFORMANT ADDRESS MARIE JORDAN, 2715 Lauretta Ave.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ACUTE ANTERO LATERAL WALL INFARCTION. (B) ARTERIO SCLEROTIC HYPERTENSIVE HEART DISEASE (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from 3-17-1967 to 3-18-1967 , that (I) (we) last saw the deceased alive on 3-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Biswanath Pillai M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3-18-67	
23C. PHYSICIAN'S NAME (Type) V. BISWANATH PILLAI M.D.				23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/67		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (State) MD			
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR Delight S. Phillips	
				ADDRESS 1227 N. Mount	

ATLANTA, GEORGIA

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WATER TREATMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 2872	
BIRTH NO. 67 2872		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John C. Simering		2. DATE AND HOUR OF DEATH March 24, 1967 3:00A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Silver Cross Home 5421 Greenwich Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Silver Cross Home B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5421 Greenwich Ave., Balto., Md. 28-04 D. STREET ADDRESS (If rural, give location)			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/3/80	9. AGE (In years last birthday) 86	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Christian Simering				14. MOTHER'S MAIDEN NAME Harriet Elizabeth Davis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Bertha K. Suwall 6120 Haddon Hall Rd.			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease with congestive heart failure 10 days INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Broncho-pneumonia, Bilateral 8 days							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from Jan 1965 to March 1967, that (I) (we) last saw the deceased alive on March 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE  Leo J. Gaver				23B. DATE SIGNED 3/24/67		23C. PHYSICIAN'S NAME (Type) M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> 23D. ADDRESS M.D. 1 Mallow Hill Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/67		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR R. B. E. Talley		25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2873	
BIRTH NO. 67 2873		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Samuel Jackson		2. DATE AND HOUR OF DEATH 20 March 1967 4 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3-01 D. STREET ADDRESS (If rural, give location) 307 Herring Court - 21231			
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2 Nov 1899	9. AGE (in years lost birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DISTRICT OF COLUMBIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Grant Jackson		14. MOTHER'S MAIDEN NAME MARGARET	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-6161		17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) massive G.I. Bleeding DUE TO (B) metastatic Carcinoma of Rectum DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, Emphysema		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION Jan 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma of Rectum		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 21 January 19 67 to 20 March 1967, that (I) last saw the deceased alive on 20 March 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Alan J. Barnes M.D.		23B. DATE SIGNED 20 March 1967		23C. PHYSICIAN'S NAME (Type) ALAN J. BARNES	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/24/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR E. L. Brown	
25C. FUNERAL DIRECTOR		25D. ADDRESS 108 W. Montgomery St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

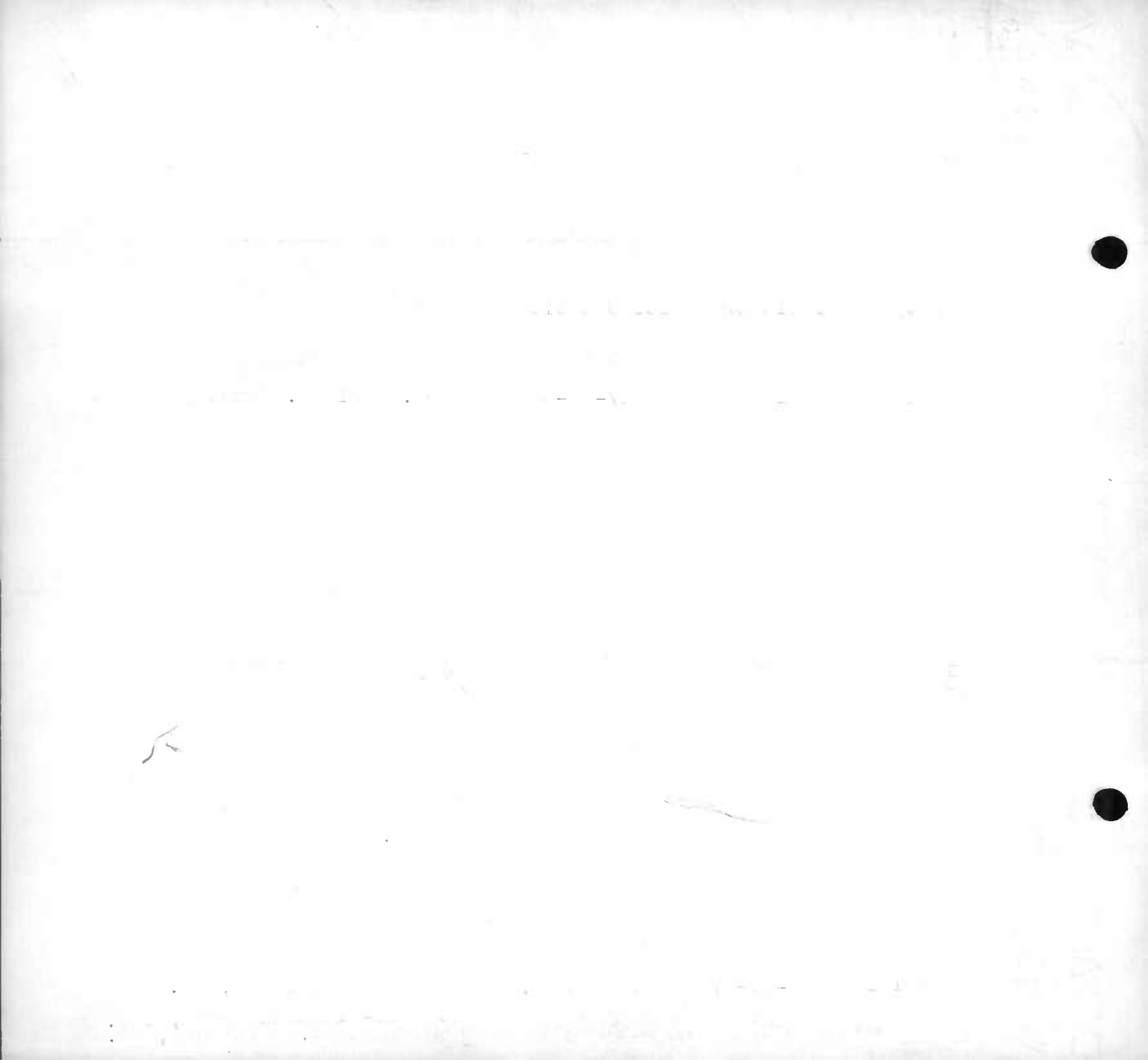
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2874</u>	
BIRTH NO. <u>67 2874</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Josephine Putney Dame</u>		2. DATE AND HOUR OF DEATH <u>March 18, 1967</u> <u>3:00 P.</u> <small>M.</small>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
(If not in hospital or institution, give street address or location) <u>1403 Park Ave.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>1401</u>			
		D. STREET ADDRESS (If rural, give location) <u>1403 Park Ave.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> <small>WIDOWED, DIVORCED (specify)</small>	8. DATE OF BIRTH <u>2/9/1882</u>	9. AGE (In years lost birthday) <u>85</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>	
13. FATHER'S NAME <u>Stephen Putney</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Withers</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-44-4169</u>		17. INFORMANT <u>T Mrs. Daniel DeButts</u> ADDRESS <u>1 Elmhurst Rd.</u>	
18. <u>473X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Congestive Heart Failure</u> <u>Pneumonia (lower lobe)</u> (A) DUE TO <u>Atherosclerotic Heart Disease</u> (B) DUE TO <u>Hypertension</u> (C) INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>15-20 yrs</u> <u>" "</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 1940</u> to <u>March 18 1967</u> , that (I) (we) last saw the deceased alive on <u>March 18 - 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE <u>W H Woody</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3-20-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. William Woody</u>		23D. ADDRESS <u>1403 Park Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/21/67</u>		24C. NAME of CEMETERY or CREMATORY <u>St. John's, Worthington Valley Balto. County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 27 1967</u>		25B. NAME OF REGISTRAR <u>P. C. E. E. E. E.</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u> ADDRESS <u>6500 York Rd. Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

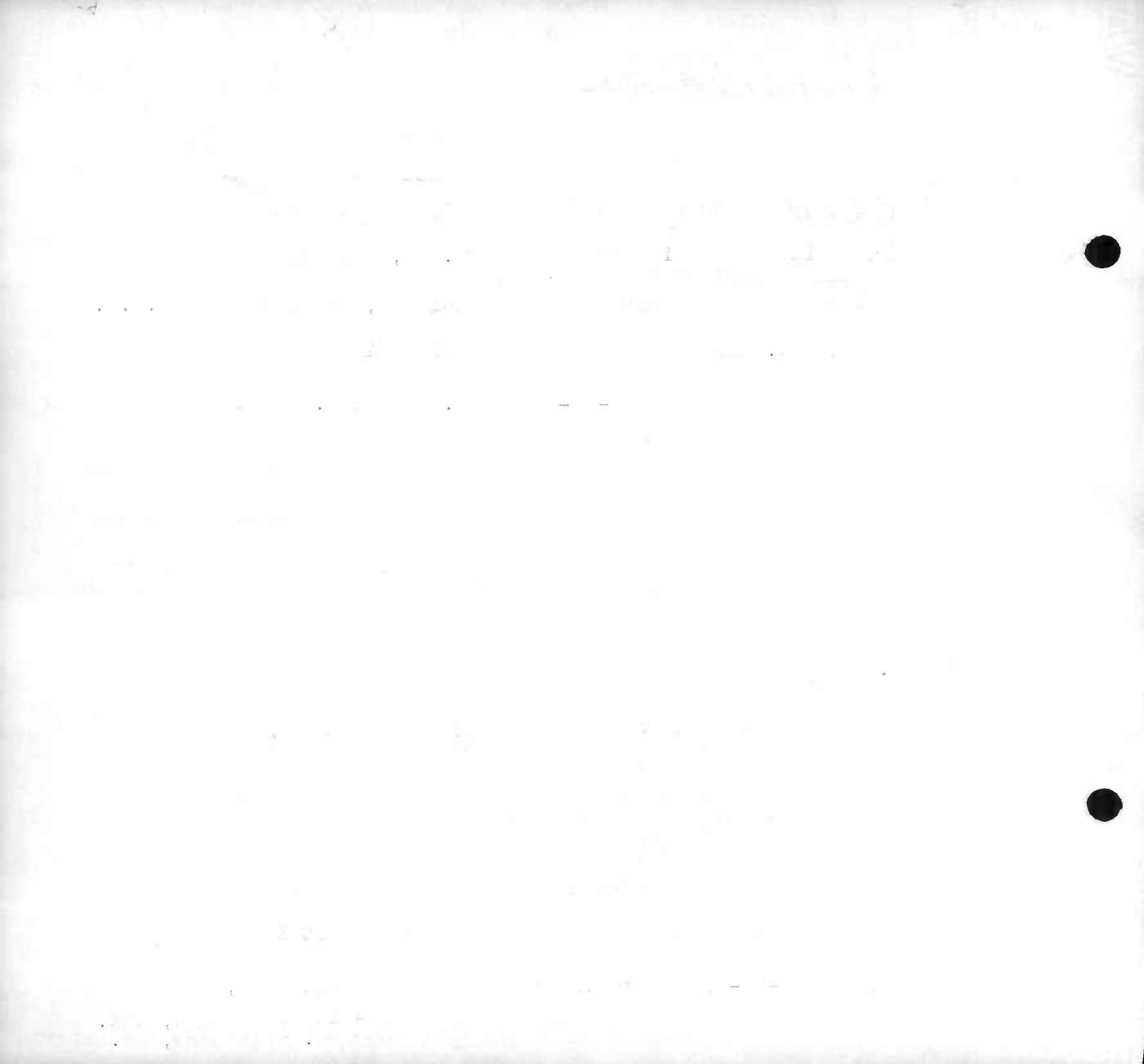
BIRTH NO. 67 2875		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2875	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) ANDREW HUGH KENNEDY			3-19-67 11640 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL			A. STATE MD 8. COUNTY A.A.C.		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena 32-00		
			D. STREET ADDRESS (If rural, give location) 410 Box 107		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/12/93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Juty Commissioner Baltimore City		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME JAMES E Kennedy			14. MOTHER'S MAIDEN NAME MARY C. Diney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-20-8468		17. INFORMANT ADDRESS A Mrs. Marie S. Kennedy Same	
18. I 1538 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Circumstances of Calm DUE TO (B) Pericardial failure DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 3-9-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Colon		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/16 1967 to 3/19/67 19____, that (I) (we) last saw the deceased alive on 3/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edwin Hirsch			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) Edwin Hirsch			23D. ADDRESS UNIVERSITY HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-67		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR A. E. F. F.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.	
				ADDRESS 2500 York Rd. Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2876		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2876	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Smith, Beulah</i>		
2. DATE AND HOUR OF DEATH <i>March 23, 1967 12:50 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 Mercy Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balt. Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>53-00 317 Murdock Road</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Aug. 31, 1878</i>	9. AGE (In years lost birthday) <i>88</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William C. Gibson</i>			14. MOTHER'S MAIDEN NAME <i>Alice Kirby</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-14-0038</i>	17. INFORMANT ADDRESS <i>Mrs. Edward J. Armstrong 621 Sussex Rd</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>451X I Renal Failure</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>AB Dominal Aneurysm</i> <i>Arteriosclerotic Cardio-vascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>years</i> <i>years</i>
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/21/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Abdominal aneurysm</i>	20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>March 21</i> 19 <i>67</i> to <i>March 23</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 23</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John Gary Green</i> M.D.			23B. DATE SIGNED <i>3/23/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>John Gary Green</i> M.D.			23D. ADDRESS <i>Mercy Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-25-67</i>	24C. NAME of CEMETERY or CREMATORY <i>Baltimore</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	25C. FUNERAL DIRECTOR ADDRESS <i>Mitchell-Wiedefeld Home, Inc. 2500 York Rd. Baltimore, Md. 21212</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2877</u>	
BIRTH NO. <u>67 2877</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Hornen, Archie B.</u>		2. DATE AND HOUR OF DEATH <u>MARCH 23, 1967</u> <u>5:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital.</u>		4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE <u>14. E. Lafayette Ave.</u> B. COUNTY <u>Baltimore, Maryland</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>12-05</u>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>May 8, 1892</u>		9. AGE (In years last birthday) <u>74</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William J. Horner</u>		14. MOTHER'S MAIDEN NAME <u>Esther Seese</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>375-10-5481</u>		17. INFORMANT <u>George Horner</u> ADDRESS <u>1720 Price St.</u>	
18. <u>423.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Aspiration Pneumonia</u> DUE TO (B) <u>Occlusion of Left Internal Carotid Artery with Hemiparesis</u> DUE TO (C) <u>Arteriosclerotic Cardiac Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Phys</u> <u>Year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic Hypertension, Emphysema</u>		19A. DATE OF OPERATION <u>3/2/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Left Carotid Occlusion</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 22, 1967</u> to <u>March 23, 1967</u> , that (I) (we) lost saw the deceased alive on <u>March 23, 1967</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John G. Green</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/23/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. John Green</u>		M.D.		23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/27/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Richland Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Geisestown, Pennsylvania</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 27 1967</u>		25B. NAME OF REGISTRAR <u>John E. Johnson</u>	
25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u>		ADDRESS <u>6500 York Rd. Balto., Md. 21212</u>			

V.S. 153

3-27-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department						Registered No. <u>67 2878</u>
BIRTH NO. <u>67 2878</u>		CERTIFICATE OF DEATH				
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>James Vincent Bennett 2 8</u>		2. DATE AND HOUR OF DEATH <u>March 21, 1967</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 2209 Homewood Ave.</u> 4-4-67			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 9-08</u> D. STREET ADDRESS (If rural, give location) <u>2209 Homewood Ave.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>6/10/1901</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>custodian, Baltimore City</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		
13. FATHER'S NAME <u>Edward M. Bennett</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes W W II</u>			17. INFORMANT ADDRESS <u>Miss Catherine M. Bennett 2209 Homewood Ave.</u>			
16. SOCIAL SECURITY NO. <u>216-07-1966</u>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>		CAUSE OF DEATH <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes mellitus</u>		(B) <u>Coronary artery arteriosclerosis 5+ years</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>May 11 1964</u> to <u>March 21 1967</u> , that (I) (we) last saw the deceased alive on <u>March 10 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Richard N. Tillman</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>March 22 1967</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard N. Tillman</u>		23D. ADDRESS <u>3025 St. Paul St.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3/24/67</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 27 1967</u>	25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2879		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2879	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Edward Williams		2. DATE AND HOUR OF DEATH 3/19/67 9 ⁰³ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND	
		B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		6-01 37 N. DECKER STREET - 21224	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/29/78	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self-employed - carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Christopher C. Williams		14. MOTHER'S MAIDEN NAME ISABELLE Hodges	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-5738		17. INFORMANT RECORDS: BCH, 4940 Eastern Avenue, Balto, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I Cerebral vascular accident HSCVD		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 2/21/67 to 3/19/67 and that (I) (we) last saw the deceased alive on 3/19/67 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. J. Owellen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/19/67	
23C. PHYSICIAN'S NAME (Type) R. J. Owellen		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR R. J. Owellen	
25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home		ADDRESS 6500 York Rd. Balto., Md. 21212			

Estimated value of property

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Estimated value of property

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 2880		67 2880	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
KATHERINE RICHTER			3/19/67 9:00 A.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Baltimore City Hospitals 4920 Eastern Avenue-21224			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			2702 Woodsdale Avenue 21228		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	White	Widowed	12/26/92	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker			Maryland		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Rothenberg			Martha Kessler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no		NO	Mrs. Wm. I. Norris 420 Oakland Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) PNEUMONIA		20 days
ANTECEDENT CAUSES			(B) INTRACEREBRAL HEMORRHAGE		20 days
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) CONGESTIVE HEART FAILURE		20 days
II			HYPERTENSION		10 YEARS
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
3/13/67	TRACHEOSTOMY		yes		yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 3/11 1967 to 3/19 1967, that (1) (we) last saw the deceased alive on 3/18 1967 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. David Swimmer			3/19/67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. David Swimmer			Baltimore City Hospitals 4940 Eastern Avenue-Balto. 21224, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	3/22/67	Mt. Olivet		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 27 1967		Robert E. Taylor		Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212	

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CERTIFICATE OF DEATH

Registered No.

FUNERAL DIRECTOR: IMPORTANT

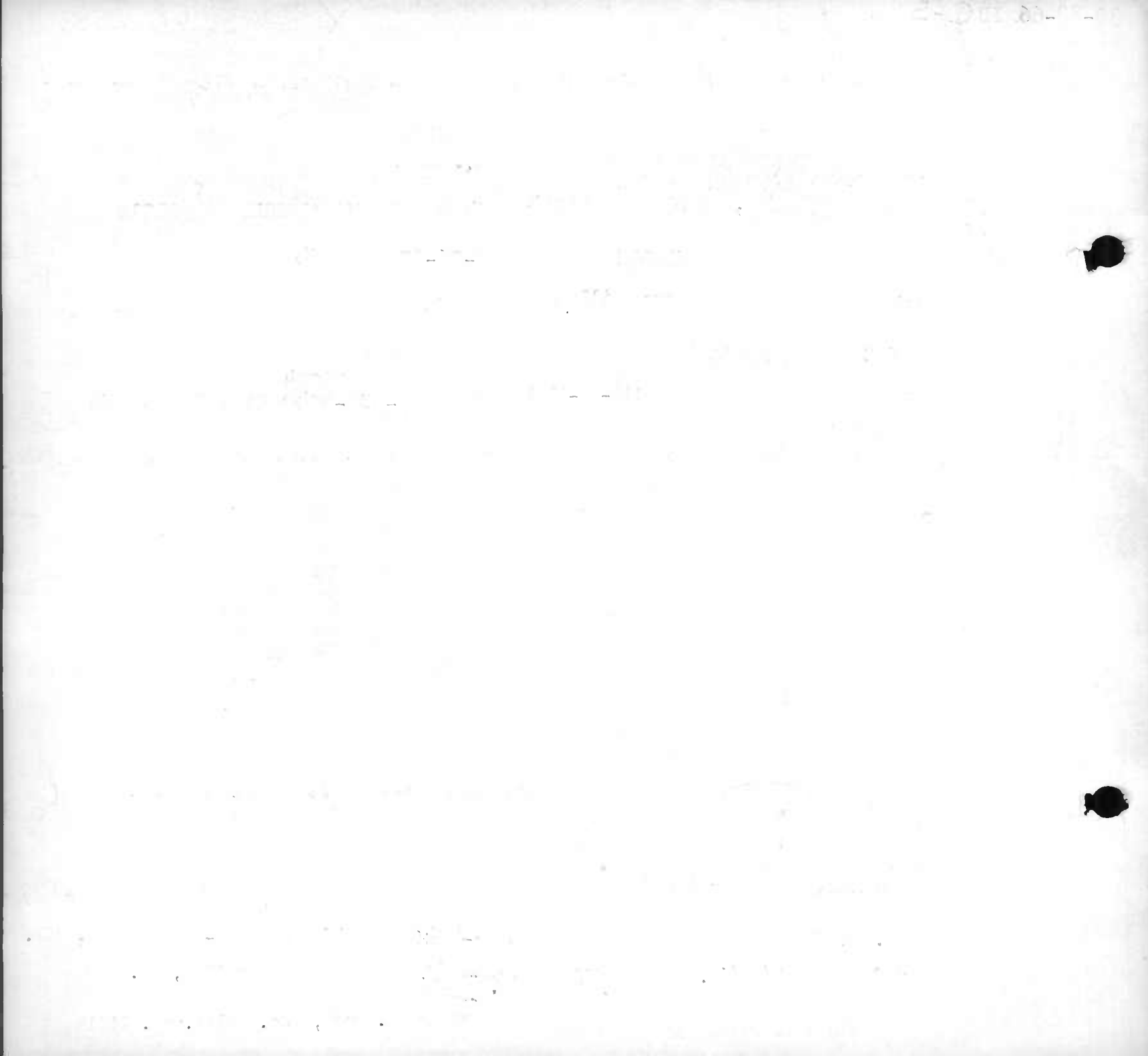
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2881		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2881	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Genevieve (Jennie) V. Schramm		2. DATE AND HOUR OF DEATH 3/24/67 16 ³⁰ AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 19 Cockpit Street 21220			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-20-78	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Robert L. Parker		14. MOTHER'S MAIDEN NAME Mary C. Reynolds			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-12-6425		17. INFORMANT Records: BCH-4940 Eastern Avenue	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Central Vase. Accident DUE TO (B) Atherosclerosis - generalized DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Generalized atherosclerosis		30 yrs	
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/4 1966 to 3/24 1967, that (I) (we) last saw the deceased alive on 3/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William A. Emerson		M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/24/67	
23C. PHYSICIAN'S NAME (Type) William A. Emerson		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25A. NAME OF REGISTRAR Robert E. Taylor, MD		25B. FUNERAL DIRECTOR Leonard J. Buck, Inc. Balto. Md. 21214			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

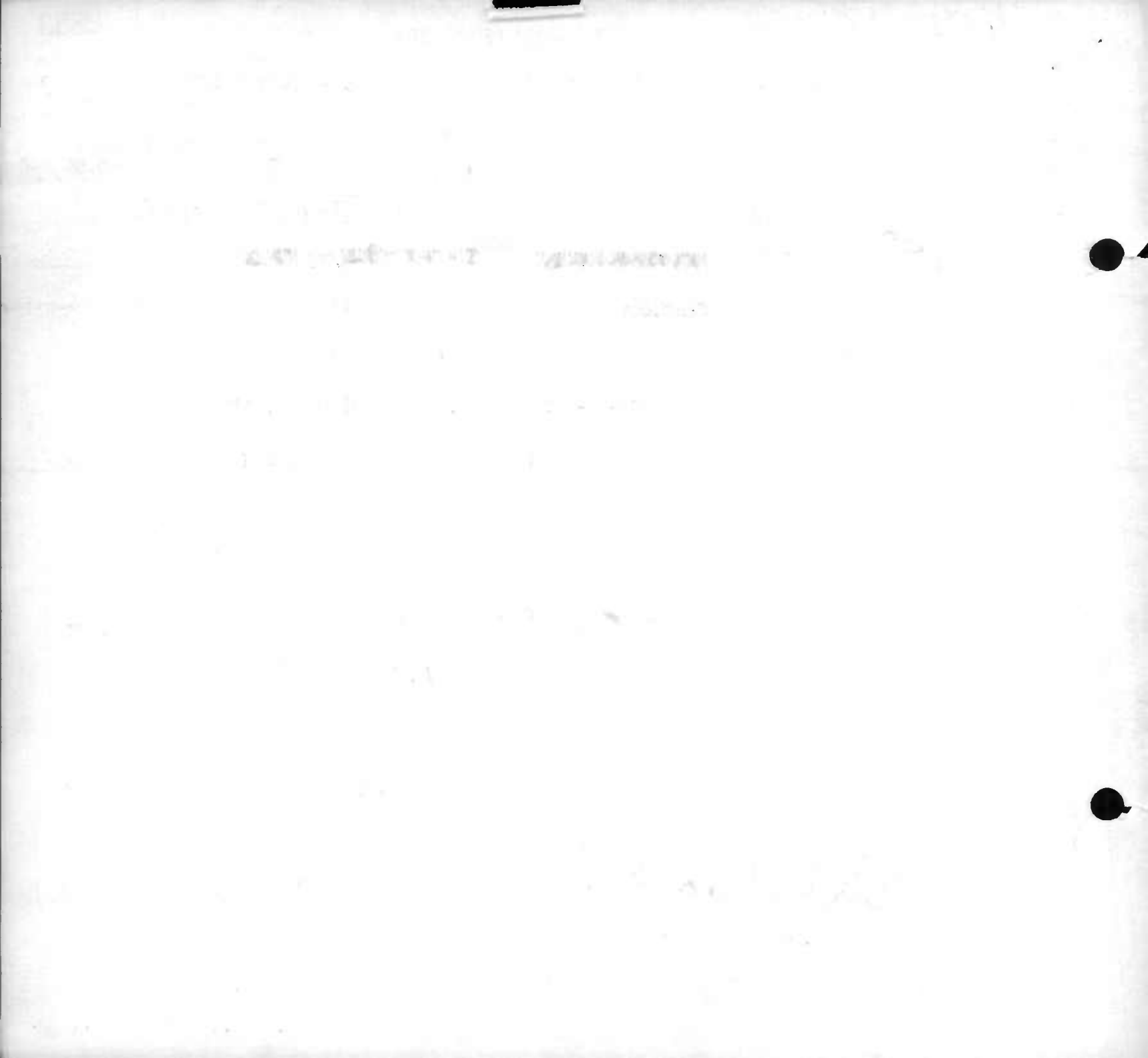
BIRTH NO. C-51467 2882		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2882	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GEORGE A. CAMPBELL		2. DATE AND HOUR OF DEATH 23 MARCH 1967 4¹⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		A. STATE MARYLAND B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6400 BELLONA AVENUE #21212			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8-26-02	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Mercy Villa		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACOB CAMPBELL		14. MOTHER'S MAIDEN NAME ETTA PRICE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 114-01-0351		17. INFORMANT #21224	
18. 578X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) G. I. Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. UNKNOWN.		CAUSE OF DEATH (A) G. I. Hemorrhage DUE TO UNKNOWN. (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>31 December 1966</u> to <u>23 MARCH 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>23 MARCH 19 67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Daniel W. Foote		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 23 MARCH, 1967	
23C. PHYSICIAN'S NAME (Type) DR. DANIEL W. FOOTE		23D. ADDRESS #21224 BCH-4940 EASTERN AVENUE-BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/67.		24C. NAME OF CEMETERY or CREMATORY Knoxville Cemetery	
24D. LOCATION (City, town, or county) (State) Knoxville, Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR MAR 27 1967		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2883	
<div style="display: flex; justify-content: space-between;"> <div> M-4 55 67 2883 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MILLMAN, HARRY			2. DATE AND HOUR OF DEATH 3-22-67 6:10 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALT C. CITY OR TOWN (If outside city limits, write RURAL and give township) 9 D. STREET ADDRESS (If rural, give location) 6124 STUART AVE		
5. SEX MALE	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 72	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME ISRAEL MILLMAN		
14. MOTHER'S MAIDEN NAME LEAH ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 216-32-8111			17. INFORMANT MRS. KATHERINE DAVIS, 6124 STUART AVENUE #9		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 490 X-1-151X Pneumonia U.I.			INTERVAL BETWEEN ONSET AND DEATH ? days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Ca Stomach ? Months		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-22-1967 10:15 AM to 3-22-1967 6:10 PM and that (I) (we) lost the deceased on 3-22-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Gordon M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3-22-67	
23C. PHYSICIAN'S NAME (Type) Dr. Stephen Gordon				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/67		24C. NAME OF CEMETERY or CREMATORY Moses Montifiore	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE (State) Md			
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Farlow		25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 67 2884	
BIRTH NO. 67 2884		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Lipsetts, Hulda.			2. DATE AND HOUR OF DEATH 3/22/67 2:10 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Srnaei Hospital.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. B. COUNTY BaltCo. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore. 53-00 D. STREET ADDRESS (If rural, give location) 8206 Arrowhead Rd.		
5. SEX Female	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11-21-51	9. AGE (In years last birthday) 15	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME SIMON ROSENBLUM			14. MOTHER'S MAIDEN NAME RACHAEL ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MR. NATHAN LIPSETTS, 8206 ARROWHEAD ROAD #8	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pericardial effusion.			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinomatous.			DUE TO 1 year.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ca. Breast.			DUE TO more than 1 year.		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 170 X I			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none.		
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/21 19 67 to 3/22 19 67 , that (I) (we) last saw the deceased alive on 3/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Erwin H. Hesseltberg M.D.			23B. DATE SIGNED 3/22/67		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 3/23/67		
24C. NAME OF CEMETERY or CREMATORY CHIZUK AMINO (ARLINGTON)			24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			25B. NAME OF REGISTRAR R. E. Taylor		
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 67 2885					CERTIFICATE OF DEATH					Registered No. 67 2885									
M.E. CASE NO.										1. NAME OF DECEASED (Type or Print) <u>HORESH, GURGI</u>					2. DATE AND HOUR OF DEATH <u>3/22/67</u> <u>2:40 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI HOSPITAL</u>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>27-17</u>				
D. STREET ADDRESS (If rural, give location) <u>3205 W. ROGERS AVE #15</u>										5. SEX <u>M</u>					6. RACE <u>W</u>				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>										8. DATE OF BIRTH <u>1/19/03</u>					9. AGE (In years lost birthday) <u>64</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>										10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>					11. BIRTHPLACE (State or foreign country) <u>Baghdad, Iraq</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>										13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>										16. SOCIAL SECURITY NO. <u>NO</u>					17. INFORMANT <u>HEBREW FREE BURIAL SOCIETY</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>420.17-016X</u>										CAUSE OF DEATH (A) <u>H A S C V D ? M.I.</u> DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>										(B) <u>ABDOMINAL ANEURYSM + RENAL STENOSIS</u> DUE TO					(C) <u>TBC OF the KIDNEY</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)										21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <u>3/20/1967</u> to <u>3/22/1967</u> , that (I) (we) last saw the deceased alive on <u>3/22/1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Hyman Greenfield</u>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>3/22/67</u>				
23C. PHYSICIAN'S NAME (Type) <u>HYMAN GREENFIELD</u>										M.D.					23D. ADDRESS <u>SINAI HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>										24B. DATE <u>3/23/67</u>					24C. NAME OF CEMETERY or CREMATORY <u>OTHER SHALOM</u>				
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>										25A. DATE REC'D BY HEALTH DEPT. <u>MAR 27 1967</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				
25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u>										ADDRESS <u>6010 REISTERSTOWN</u>									

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2886	
BIRTH NO. 67 2886		CERTIFICATE OF DEATH	
M.E. CASE NO.		(WILLIE)	
1. NAME OF DECEASED (Type or Print) GREIF, WILLIAM		2. DATE AND HOUR OF DEATH 3/20/67 5:35A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42 OF BALTIMORE		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4705 PARMELEE RD	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID	8. DATE OF BIRTH 4/17/84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL		10B. KIND OF BUSINESS OR INDUSTRY BROOM MAKER	9. AGE (In years last birthday) 82
13. FATHER'S NAME ? GREIF		11. BIRTHPLACE (State or foreign country) AUSTRIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 110-07-2110A	12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT Mr. Joseph A. Greif, 4705 Parmelee Road #8		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO ASND (B) DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH 1 DAY 20 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/19 1967 to 3/20 1967, that (I) (we) last saw the deceased alive on 3/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David A. Spott		23B. DATE SIGNED 3/20	
23C. PHYSICIAN'S NAME (Type) D.A. SPOTT		23D. ADDRESS SINAI HOSP. + BALT	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Removal		24B. DATE 3/22/67	
24C. NAME of CEMETERY or CREMATORY Beth David		24D. LOCATION (City, town, or county) (State) Elmont Long Island, New York	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2887</u>	
67 2887		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Goldstein Hilda</u>		2. DATE AND HOUR OF DEATH <u>3/21/67</u> <u>10¹⁵ A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-18</u> D. STREET ADDRESS (If rural, give location) <u>3319 W Garrison Ave.</u>			
5. SEX <u>Fe-</u>	6. RACE <u>Cauc.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH	9. AGE (In years lost birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-0111B</u>		17. INFORMANT ADDRESS <u>Mr. Louis Goldstein, 3319 Garrison Avenue</u>	
18. <u>42011</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Myocardial Infarction</u> DUE TO (B) <u>Arteriosclerotic Cardiovascular</u> DUE TO (C) <u>many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic Acute Cholecystitis</u>		years.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/26/67</u> 19 <u>67</u> to <u>3/21</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>3/21/67</u> and that in my <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>viewed</u> the body after death.					
23A. SIGNATURE <u>Erwin H. Hesselberg</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>3/21/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/22/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Beth Hamedrosh Hagodol</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 27 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 60 67 2888		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2888	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Herman Schofer		2. DATE AND HOUR OF DEATH March 21, 1967 11:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-20 D. STREET ADDRESS (If rural, give location) 7111 Park Heights Avenue			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH MAY 19 1900	9. AGE (In years last birthday) 68 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME Isaac Schofer		14. MOTHER'S MAIDEN NAME Lena ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Mrs. Daniel Mendelsohn, Owings Mills, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4-20-1 I INTERVAL BETWEEN ONSET AND DEATH Myocardial Infarction 1-2 minutes		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Coronary Arteriosclerosis		M.D. CHIEF OR ASST. MEDICAL EXAMINER	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) RS F	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 21 1967 to March 21 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 21 1967 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Silva		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED March 21, 1967	
23C. PHYSICIAN'S NAME (Type) Joseph Silva		23D. ADDRESS M.D. The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/67		24C. NAME of CEMETERY or CREMATORY Anshe Emunah- (Aitz Chaim)	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR [REDACTED]		25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2889				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2889	
M.E. CASE NO.				A.M.			
1. NAME OF DECEASED (Type or Print) Katie Wiencke				2. DATE AND HOUR OF DEATH Mar. 23, 1967 11:00			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 1105 E. Fayette Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-06 D. STREET ADDRESS (If rural, give location) 2821 Roselawn Ave			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 7-16-1866	9. AGE (In years lost birthday) 100	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Wiencke				14. MOTHER'S MAIDEN NAME Helen Simon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 56 4732J		17. INFORMANT ADDRESS Mrs Lena Lindhorst 2821 Roselawn			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident 2 weeks				INTERVAL BETWEEN ONSET AND DEATH Many years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ASCVD DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (XXXXXX) attended the deceased from Jun 1, 1953 to Mar 23, 1967 , that (I) (XX) last saw the deceased alive on Mar 21, 1967 and that in my (Mr) opinion death occurred on the date and hour and from the causes stated above. (I) (XX) (did) (XXXX) view the body after death.							
23A. SIGNATURE E Ellsworth Cook				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-23-67	
23C. PHYSICIAN'S NAME (Type) Dr. E. Ellsworth Cook				23D. ADDRESS 2431 Maryland Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-25-67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., Md.	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Stanley Miller - 2334		ADDRESS Jefferson	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2890		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2890	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lydia M. Caroly</i>		2. DATE AND HOUR OF DEATH <i>3/22/67 8:40 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Belt Air</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Bel Air</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Gould's Convalescarium</i>		D. STREET ADDRESS (If rural, give location) <i>Rd #1, Box #51</i>		E. ZIP CODE <i>21014</i>	
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED-NEVER MARRIED WIDOWED-DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>1/16/1886</i>	9. AGE (In years lost birthday) <i>81 years</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Education</i>		11. BIRTHPLACE (State or foreign country) <i>New York City - NY</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>Emile Caroly</i>		14. MOTHER'S MAIDEN NAME <i>Olga Tolentino</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>216-46-7443</i>		17. INFORMANT <i>Albert C. Mencia</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Insufficiency</i>		19. CAUSE OF DEATH (A) DUE TO <i>Anteroseptal Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Chronic Brain Syndrome</i>		(B) DUE TO <i>Depression</i>		<i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Depression</i>		(C) DUE TO			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Apr. 19 63</i> to <i>March 22 19 67</i> , that (I) (we) lost saw the deceased alive on <i>Feb. 24 19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i>				23B. DATE SIGNED <i>3/22/67</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>3/25/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore - Md - 21212</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Stokely</i>	
25C. FUNERAL DIRECTOR <i>Carl B. Walberton Funeral Home Inc</i>		25D. ADDRESS <i>6300 - Belair Rd, Balto, Md 21216</i>			

My dear Mr. B. B. King
I have been thinking of you
very much lately.

Yours truly
Martin Luther King Jr.

Mr. B. B. King

3/25/68

H-635 67 2891

BALTIMORE CITY HEALTH DEPARTMENT

67 2891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST HARDING

2. DATE AND HOUR PRONOUNCED DEAD

3-22-67

7:15 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

851 GEORGE STREET - Crew of Amb. #1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

8. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

851 George Street - Apt. 9B 21201

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married (Sep)

8. DATE OF BIRTH

Dec. 3, 1919

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Shadmack Harding

14. MOTHER'S MAIDEN NAME

Lizzie Laws

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; if yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Amy Vandewall 851 George St. 9/13

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXXX~~

Hypertensive and arteriosclerotic

cardiovascular disease

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-22-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

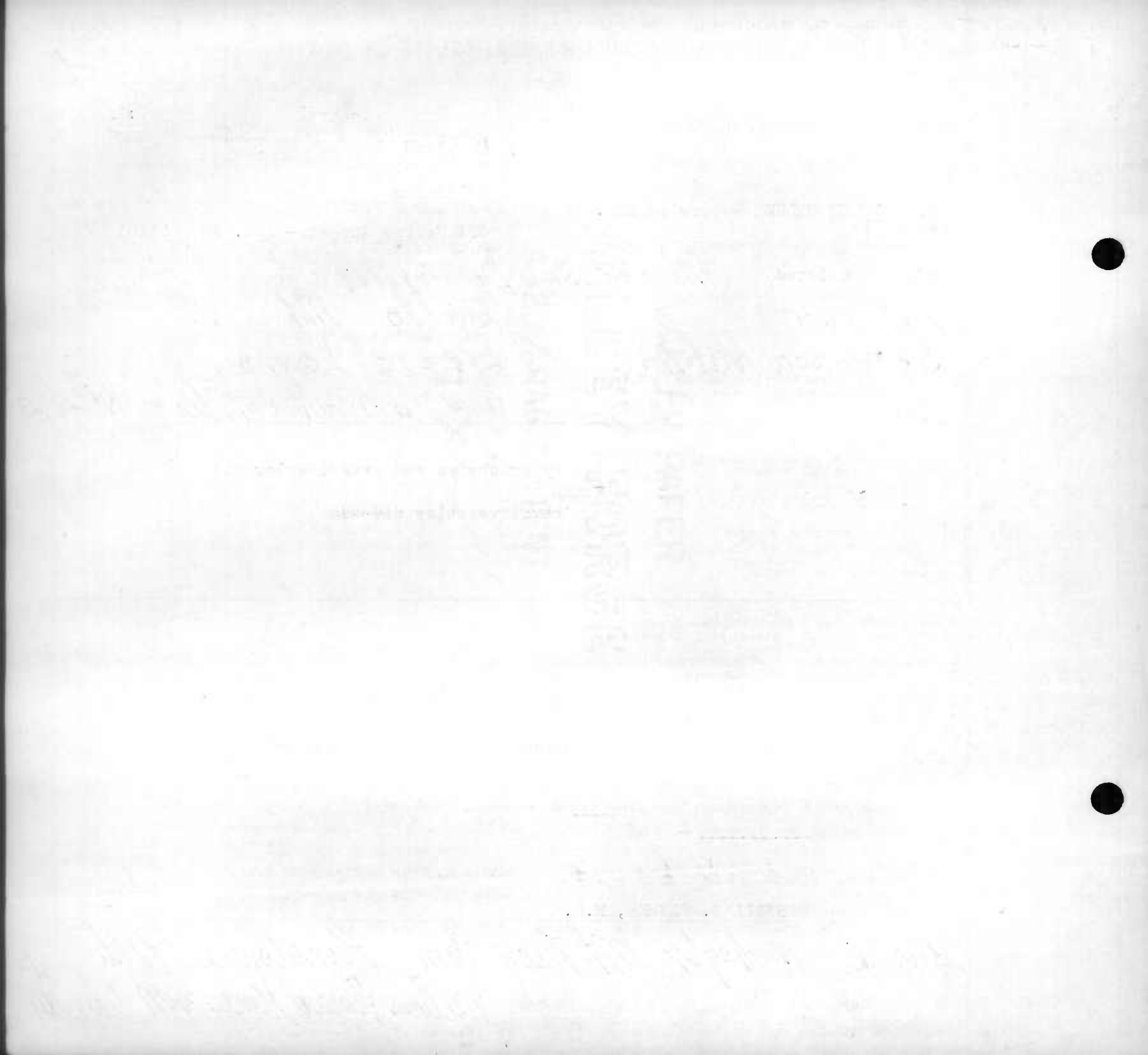
23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-41667 2892		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2892	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth Gilbert</i>		3/23/67 5 ¹⁵ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224		A. STATE Maryland B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 26 Yorkway Rd. 21222			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-7-08	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Curtis TERRANCE CURTIN		14. MOTHER'S MAIDEN NAME Julia SULLIVAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-20-4766		17. INFORMANT Maryland #21224 BCH: Records 4940 Eastern Ave. Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Intra cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 20 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3/22/67 19 to 3/23 19 67, that (I) (we) last saw the deceased alive on 3/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William A. Emerson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/23/67	
23C. PHYSICIAN'S NAME (Type) William A. Emerson		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/26/67		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER, BALTIMORE, MD	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Rudolph, Rudolph, & Rudolph, Inc.		25D. ADDRESS			

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CERTIFICATE OF DEATH

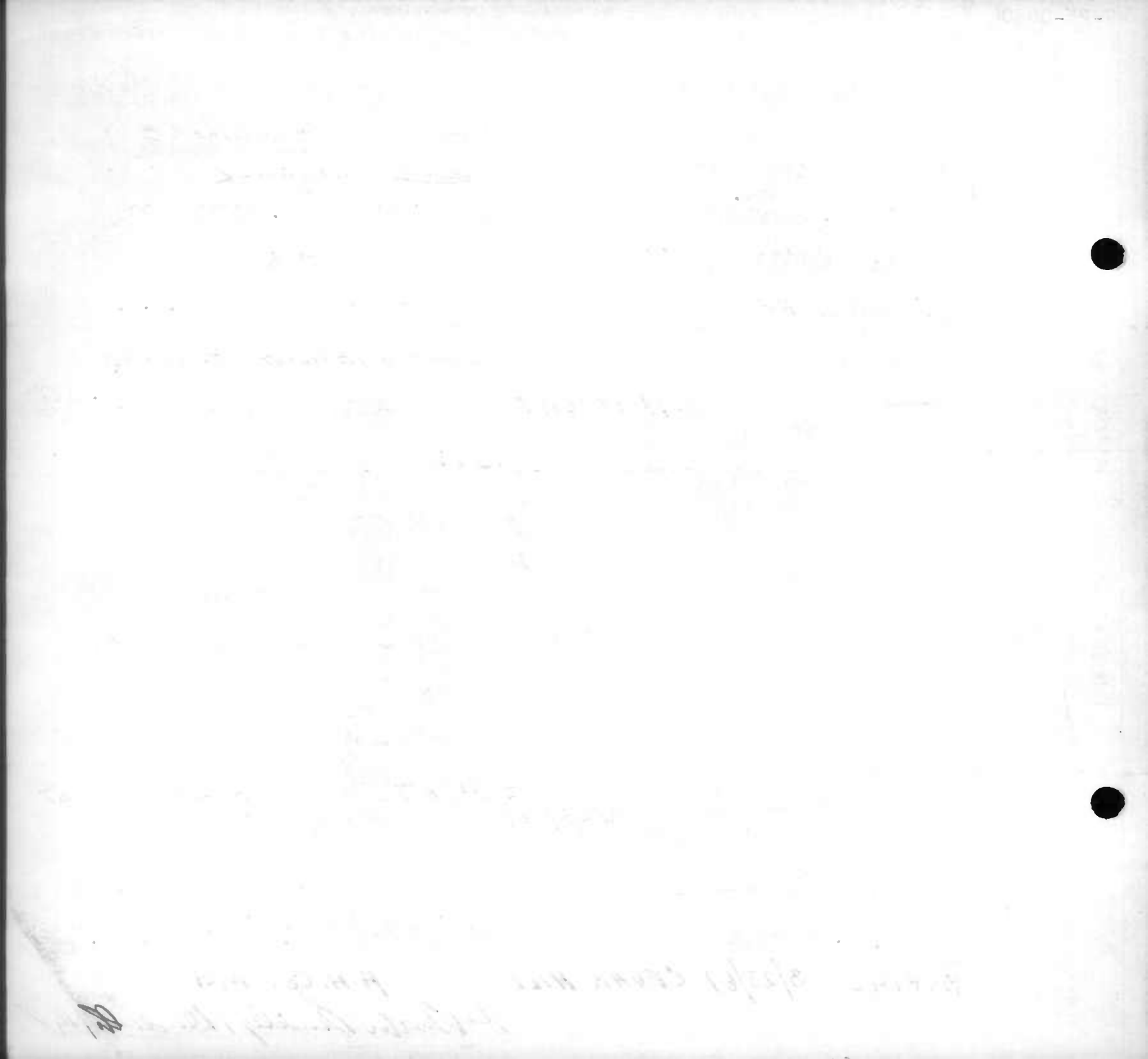
Registered No.

67 2893

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 2893		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Matilda Alice King</i>		2. DATE AND HOUR OF DEATH <i>3/23/67</i> <i>4 45</i> AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave.</i> <i>Baltimore, Maryland # 21224</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALTIMORE Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>DUNDALK</i> <i>53-00</i> D. STREET ADDRESS (If rural, give location) <i>119 Williams Ave. 21222 005</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>12-12-90</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <i>76</i>
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Powers</i>		14. MOTHER'S MAIDEN NAME <i>Unknown MATILDA HENNESSY</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-07-0517</i>	
17. INFORMANT <i>BCH: Records 4940 Eastern Ave. Md. 21224</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>ASCVD heart fail</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Hypertension</i>		(B) DUE TO <i>Hypertension</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertension</i>		(C) DUE TO	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/14/67</i> 19 to <i>3/23</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/23/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Wm A. Emerson</i>		23B. DATE SIGNED <i>3/23/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Wm A. Emerson</i>		23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave. Baltimore, Md. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3/25/67</i>	
24C. NAME of CEMETERY or CREMATORY <i>CEDAR HILL</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. Co. Md.</i>	
25A. DATE RECEIVED BY DEATH CERTIFICATE <i>MAR 27 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Lyndon Family, Dundalk, Md.</i>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2894				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2894	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VINCAS PETRAUSKAS				2. DATE AND HOUR OF DEATH MARCH 24, 1967 8:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 19-03 D. STREET ADDRESS (If rural, give location) 1525 W. PRATT ST. (21223)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/3/89	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teller		10B. KIND OF BUSINESS OR INDUSTRY Clothing Co.		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Brown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215054238		17. INFORMANT CHART		ADDRESS	
18. 337X I CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CVA				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/22 19 67 to 3/24 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 3/24 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ferdinand C. Rodriguez M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/24/67	
23C. PHYSICIAN'S NAME (Type) FERDINAND C. RODRIGUEZ M.D.				23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/67		24C. NAME of CEMETERY or CREMATORY New Catholic Cem.		24D. LOCATION (City, town, or county) (State) Beth. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR John J. Brown, Jr.		ADDRESS 901 Hallis St. Balto. Md. 31223	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2895		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2895	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Moreland, Joseph Newton</i>		2. DATE AND HOUR OF DEATH <i>March 22, 1967 3 P</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial</i>		A. STATE <i>MD</i>			
(If not in hospital or institution, give street address or location)		B. COUNTY			
<i>44</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 27-01</i>			
		D. STREET ADDRESS (If rural, give location) <i>4003 EIERMAN AVE.</i>			
5. SEX <i>Male</i>	6. RACE <i>Cauc</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>06-20-95</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>	
13. FATHER'S NAME <i>Benjamin Moreland</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOSEPH MORELAND JR, 4003 EIERMAN AVE.</i>	
18. <i>491X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>full</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Arteriosclerotic heart disease.</i>			
19A. DATE OF OPERATION <i>2</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>YES</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>March 13 1967</i> to <i>March 22 1967</i> , that (I) (we) last saw the deceased alive on <i>March 22 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joe T. Chandler</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>March 22, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOE T. CHANDLER</i>		23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>3-26-67</i>	24C. NAME of CEMETERY or CREMATORY <i>Salem Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Slanesville, W. Va.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>	25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	25C. FUNERAL DIRECTOR <i>ILLERICH FUNERAL HOME, BALTO, MD</i>		ADDRESS	

Handwritten text at the top left, possibly a date or reference number.

Handwritten text in the upper middle section.

Handwritten text in the middle left section.

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Handwritten number '234' on the left.

Handwritten number '234' on the right.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/76

RECEIVED

March 11 1892
J. C. Schwaner
J. C. Schwaner
J. C. Schwaner

Montague County, Texas
J. C. Schwaner
J. C. Schwaner

March 11 1892
J. C. Schwaner
J. C. Schwaner

March 11 1892
J. C. Schwaner
J. C. Schwaner

P-412

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 2897		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2897	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Elwood John Phillips		2. DATE AND HOUR PRONOUNCED DEAD 3 17 67 140 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Wicomico Co.	
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salisbury 72-12	
		D. STREET ADDRESS (If rural, give P.O. address) 1001 Spring Ave.	
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/8/26
9. AGE (In years last birthday) 40		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Frieght Co.	
11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Phillips		14. MOTHER'S MAIDEN NAME Agnes Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222 14 2260	
17. INFORMANT Dorothy I. Phillips, Salisbury, Md.		18. CAUSE OF DEATH Myocardial Infarct	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Rheumatic heart disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WERNER U. SPITZ		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3.18.67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/21/67	
23C. NAME of CEMETERY or CREMATORY St. Johnstown Cemetery		23D. LOCATION (City, town, or county) (State) Greenwood, Del.	
24A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		24B. NAME OF REGISTRAR Robert E. Farley, Jr.	
24C. FUNERAL DIRECTOR William B. Benge		ADDRESS Milford, Del.	

2011 V. 311-16

2011 V. 311-16

White

White

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5-522

67 2898

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 2898

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM J. SENKUS

2. DATE AND HOUR PRONOUNCED DEAD

March 22, 1967 8:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1313 W. Lombard Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1313 W. Lombard Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

11/15/1903

9. AGE (In years lost birthday)

63

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Presser

10B. KIND OF BUSINESS OR INDUSTRY

Clothing Co.

11. BIRTHPLACE (State or foreign country)

Beth. Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vincent W. Senkus

14. MOTHER'S MAIDEN NAME

Anna Butkus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
The Marie Robertson 1313 W. Lombard St.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/23/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3/27/67

23C. NAME of CEMETERY or CREMATORY

Greenridge Mem. Ch.

23D. LOCATION

(City, town, or county)

Beth. Ind.

24A. DATE REC'D BY HEALTH DEPT.

MAR 27 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

John J. Conway, Sr. Inc. 901 Hollins St.

ADDRESS

Beth. Ind. 23, ✓

11/12/1903

12th St

San Francisco

Dear Sir

I have the honor to acknowledge the receipt of your letter of the 11th inst.

in relation to the matter of the 11th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours,
J. H. [Signature]

Very truly,
J. H. [Signature]

11/12/1903

12th St
San Francisco

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2899				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2899	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LIPPINCOTT ALLEN ROBERT				2. DATE AND HOUR OF DEATH MARCH 24 1967 3:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY Harford Co.	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BEL AIR				D. STREET ADDRESS (If rural, give location) 315 BELCREST ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 02-18-24	9. AGE (In years last birthday) 43	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senior Catalog writer U.S. Army			10B. KIND OF BUSINESS OR INDUSTRY Retired - U.S. Army		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME JAY LIPRINCOTT				14. MOTHER'S MAIDEN NAME ALICE HEART HART			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1943-1958		16. SOCIAL SECURITY NO. 201-14-5499		17. INFORMANT (Wife) 838-4830 Mrs. Ruth M. Lippencott		ADDRESS 315 East Belcrest Road Bel Air, Maryland 21014	
18. 330 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Intracerebral hemorrhage Subarachnoid hemorrhage (B) Due to (C) Major surgery				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-20-67 to 3-24-67 , that (I) (we) last saw the deceased alive on 3-24-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fredrikur Bjornsson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-24-67	
23C. PHYSICIAN'S NAME (Type) FREDRIKUR BJORNSSON				23D. ADDRESS THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar. 28, 1967		24C. NAME of CEMETERY or CREMATORY Arlington National Cemetery		24D. LOCATION (City, town, or county) (State) Arlington, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014	

WHICH MEMORIALS
32E BELLEFAY
BEL AIR
BELL

24 15-81-50 231MM 3TH 3MM

05/04/2018

784 LIBRARY

NAME ~~XXXXXX~~ HGR

2-54 2-55 2-56 2-57 2-58 2-59 2-60 2-61 2-62 2-63 2-64 2-65 2-66 2-67 2-68 2-69 2-70 2-71 2-72 2-73 2-74 2-75 2-76 2-77 2-78 2-79 2-80 2-81 2-82 2-83 2-84 2-85 2-86 2-87 2-88 2-89 2-90 2-91 2-92 2-93 2-94 2-95 2-96 2-97 2-98 2-99 2-100

FR/DT/06/01 18/04/2011

3-54

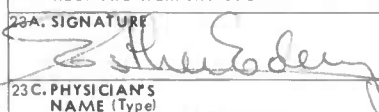
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2900		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2900	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CLABAUGH, LOUISE ELIZABETH				2. DATE AND HOUR OF DEATH MARCH 24, 1967 3:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balti. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) OWINGS MILLS 53-00 D. STREET ADDRESS (If rural, give location) BOX 263 LYONS MILL RD.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED SINGLE	8. DATE OF BIRTH 3-24-95	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT BUSINESS RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES Clabaugh			14. MOTHER'S MAIDEN NAME MARY ELLEN CLABAUGH nee Little		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 216-07-2402		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Artery Occlusion Generative Gastric Ulcer				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension, left kidney					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 12 1967 to MARCH 24, 1967 and that (I) (we) last saw the deceased alive on MARCH 24, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolando Del Rosario, M.D.				23B. DATE SIGNED 03-24-67	
23C. PHYSICIAN'S NAME (Type) Rolando Del Rosario		23D. ADDRESS St Agnes Hosp. Caton & Wilkins Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/67		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION 4300 Old Frederick Rd. Balt. Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR Rolando E. Del Rosario		25C. FUNERAL DIRECTOR ADDRESS Loring Byers-8728 Liberty Rd. Randall			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2901	
BIRTH NO. 67 2901		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 3-24-67 6:20AM	
1. NAME OF DECEASED (Type or Print) VAN HUSS XXXXXXXX, ELIZABETH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO., MD. #29		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY HOWARD Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY 63-00 D. STREET ADDRESS (If rural, give location) 440 COLUMBIA RD.	
5. SEX FEMALE	6. RACE CAUCASION	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) UNKNOWN	8. DATE OF BIRTH 07-27-10
		9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) UNKNOWNX Vader Washington
13. FATHER'S NAME EMERSON ZION		14. MOTHER'S MAIDEN NAME FLORIDA CHAMBERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 229 40 2390	
		17. INFORMANT AVES. #29	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Infocerebral hemorrhage DUE TO (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 22 19 67 to MARCH 24 19 67 , that (I) (we) last saw the deceased alive on MARCH 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 3-24-67	
23C. PHYSICIAN'S NAME (Type) ESTHER EDERY		23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-1967	
24C. NAME of CEMETERY or CREMATORY Cecil		24D. LOCATION (City, town, or county) (State) Pennington Gap, Va.	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Feltner	
25C. FUNERAL DIRECTOR F. C. Higinbotham		ADDRESS Ellicott City, Md	

2-27-6

1967 FEB 27 MON 10:00 AM

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White, Mid size

White

Reservoir White

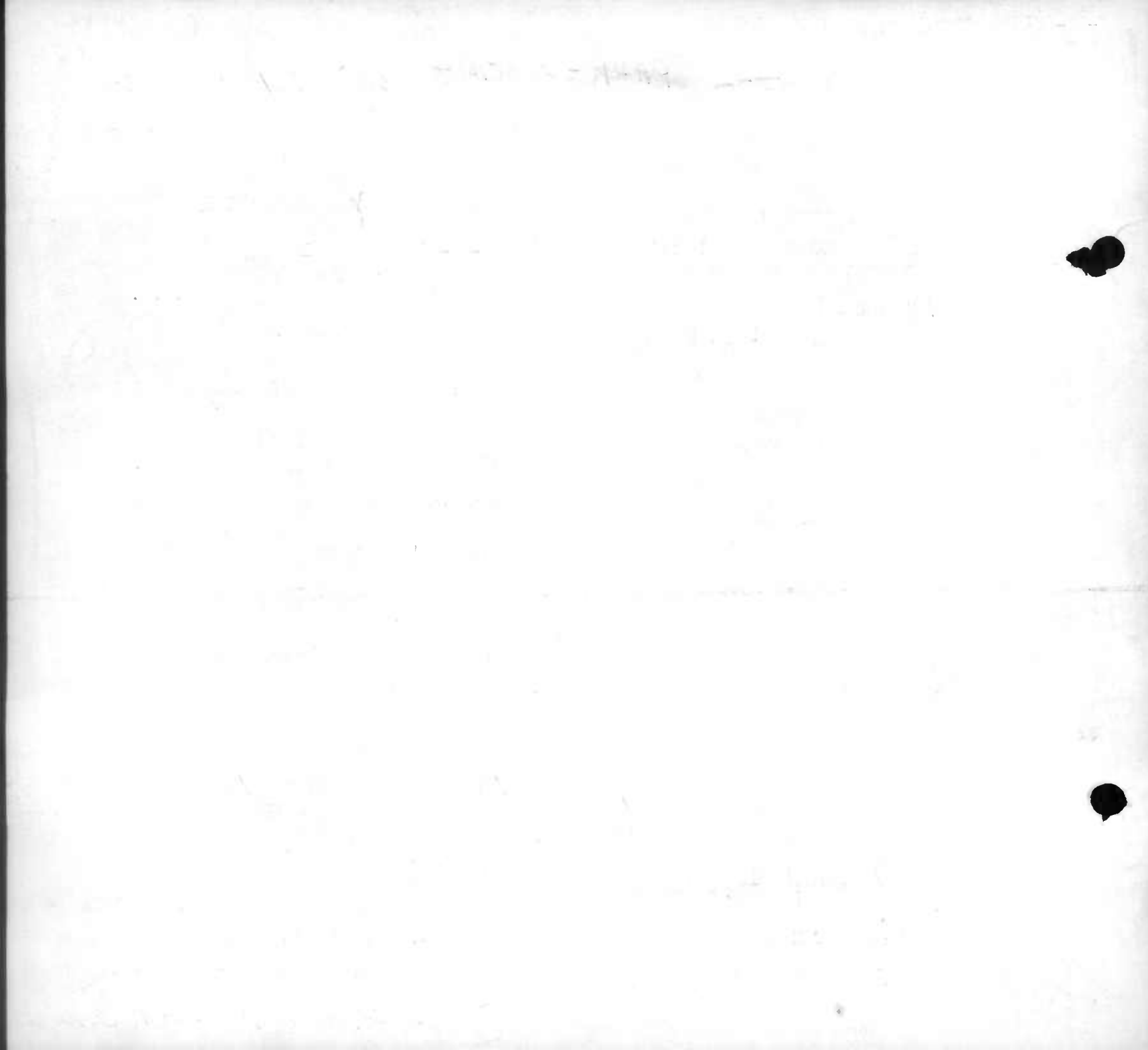
Reservoir White

1/2

2 busy lawn, m. d.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 530 67 2903		CERTIFICATE OF DEATH		67 2903	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EUELLA PARKER GANTT		2. DATE AND HOUR OF DEATH 5:30am 3/23/67 5:30 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2418 LLEWELLYN AVENUE 21213			
5. SEX FE-MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-19-06	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES PARKER		14. MOTHER'S MAIDEN NAME ROSIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH: REC ORDS 4940 EASTERN AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 201X I		CAUSE OF DEATH (A) ?Pulmonary Embolus DUE TO (B) Radiation Pneumonitis DUE TO (C) Hodgkin's Sarcoma		INTERVAL BETWEEN ONSET AND DEATH 1hr. 1week 12years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/3/17 19 67 to 3/23 19 67 , that (I) (we) last saw the deceased alive on 3/23 19 67 and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above. (I) (xxx) view the body after death.					
23A. SIGNATURE Ashley T. Haase		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. Ashley T. Haase		23D. ADDRESS 4940 EASTERN AVENUE BALTO. MD. 21224 Balt. City Hospital B2N			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 3/28/67		24C. NAME OF CEMETERY OR CREMATORY mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) a. a. County: md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph B. Locks Jr.	
25D. ADDRESS 1304 N. Central Ave					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2905		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2905	
<div> <div>M-637</div> <div>CERTIFICATE OF DEATH</div> </div>					
1. NAME OF DECEASED (Type or Print) MARTIN, MILDRED LORETTA			2. DATE AND HOUR OF DEATH MARCH 21, 1967 10:55 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL 21229 CATON AND WILKENS AVES., BALTO., MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21215 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-41 D. STREET ADDRESS (If rural, give location) 6420 REISTERSTOWN RD (SETON INSTITUTE)		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED NEVER MARRIED	8. DATE OF BIRTH 7-20-78	9. AGE (In years lost birthday) 88 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (State or foreign country) CLEVELAND, OHIO		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME JAMES W. MARTIN (DEC'D)			14. MOTHER'S MAIDEN NAME BRIDGET MARTIN (DEC'D) MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-54-9675	17. INFORMANT ADDRESS CATON & WILKENS AVES. HOSPITAL SLIP- ST. AGNES HOSPITAL		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Collapse circulatory Diabetes Gangrene leg amputated II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from MARCH 18, 19 67 to MARCH 21, 19 67, that (X) (we) lost saw the deceased alive on MARCH 21, 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. L. Lallo			23B. DATE SIGNED 3-21-67		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Paulino D. Vasallo, M.D.			23D. ADDRESS M.D. 608 Markham Rd., Balto. Md 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3/27/67	24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., City	

1. The first part of the document is a list of names and dates.

2. The second part of the document is a list of names and dates.

3. The third part of the document is a list of names and dates.

4. The fourth part of the document is a list of names and dates.

5. The fifth part of the document is a list of names and dates.

6. The sixth part of the document is a list of names and dates.

7. The seventh part of the document is a list of names and dates.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 2906		67 2906	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) THOMPSON, Mrs ISABELLA M.			2. DATE AND HOUR OF DEATH 3/24/1967 3:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. MD. 1-02		
			D. STREET ADDRESS (If rural, give location) 3114 FLEET ST. #21		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/10/1910	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Saleslady		10B. KIND OF BUSINESS OR INDUSTRY Epsteins & Co.	11. BIRTHPLACE (State or foreign country) BALTI., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME FRANK GROSS			14. MOTHER'S MAIDEN NAME MARGARET KUELLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-03-2392	17. INFORMANT ADDRESS Henry Thompson -husband, above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) CA OF COLON, METASTASIES DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5 YEARS
19A. DATE OF OPERATION 1-3/16/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BOWL OBSTRUCTION	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 3/16/67 19 to 3/24 1967, that (I) (we) last saw the deceased alive on 3/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Edward A. Person				23B. DATE SIGNED 3/24/67	
23C. PHYSICIAN'S NAME (Type) Edward A. PERSON		23D. ADDRESS 17. G. H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/23/67	24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane #13	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2907	
BIRTH NO. 67 2907		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs. Josephine Udes		2. DATE AND HOUR OF DEATH 3-23-67 8:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-01 D. STREET ADDRESS (If rural, give location) 4624 Belair Rd #6			
5. SEX M F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 4-19-07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Dvorak Bros.		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Anthony Bognanni		14. MOTHER'S MAIDEN NAME Maria Bagli	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-4843		17. INFORMANT Charles Udes, husband, above	
18. I 17/18 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) A Cerebral thrombosis DUE TO		1 wk	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Acute Myocardial Infarction DUE TO		1 wk	
		(C) Ca Cervix - Stage 2		3	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3-15-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Radical Enucleation		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 3-15-67 19 3-23 19 67 , that (I) (he) last saw the deceased alive on 3-23 19 67 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did) (did not) view the body after death.					
23A. SIGNATURE William T. Mason		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-23-67	
23C. PHYSICIAN'S NAME (Type) William T. Mason		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane #13			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2908**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

HENRY

FITCH

2. DATE AND HOUR PRONOUNCED DEAD

March 23, 1967

6:35 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

534 22nd Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

Sept. 12, 1939

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Race Track Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Nelson Co., Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Samuel Redd

14. MOTHER'S MAIDEN NAME

Nannie L. Fitch

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No16. SOCIAL
SECURITY NO.
230-44-3320

17. INFORMANT

ADDRESS

Z. H. Lewis - Waynesboro, Virginia

18. **E-87419**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Bronchopneumonia

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Multiple Cardiac Arrests
DUE TO

(C) Narcotic Intoxication.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 2 '66

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Overdose of narcotic.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/23/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-28-67

23C. NAME of CEMETERY or CREMATORY

Riverview

23D. LOCATION

(City, town, or county)

(State)

Waynesboro, Virginia

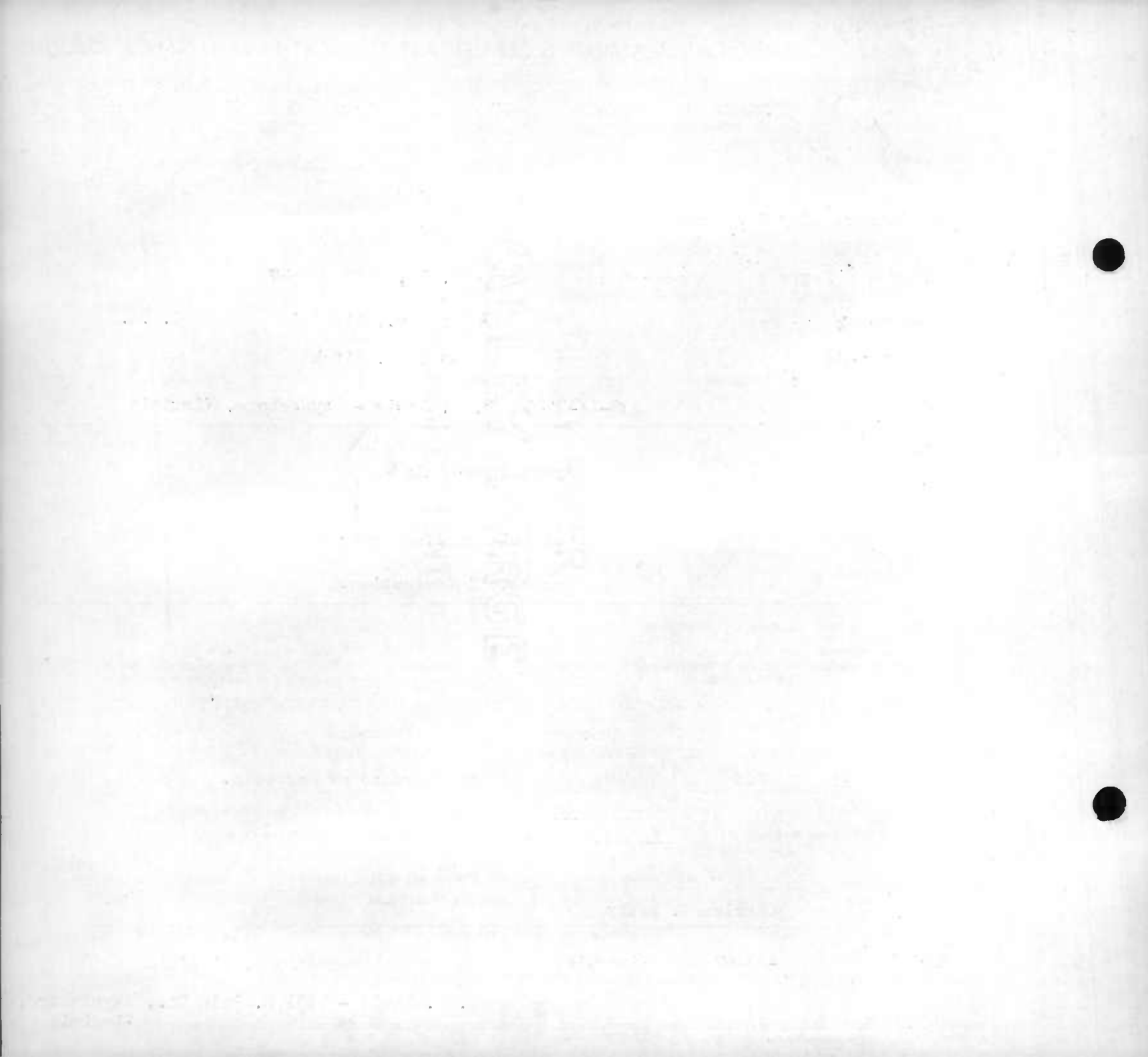
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Z. H. Lewis - 1831 E. Main St., Waynesboro,
Virginia



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2909	
BIRTH NO. 152 67 2909		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>VIRGINIA H. ROBINSON</i>		2. DATE AND HOUR OF DEATH <i>3/22/67</i> <i>1:15 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		D. STREET ADDRESS (If rural, give location) <i>2831 Winchester Street</i> <i>21216</i>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9-14-1918</i>	9. AGE (In years lost birthday) <i>48</i>	If Under 1 Yr. Months: Days: Hours: Min.
10. B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Fred Hackney</i>		14. MOTHER'S MAIDEN NAME <i>Florence</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>RECORDS: BCH 4940 Eastern Avenue 21224</i>		ADDRESS	
18. CAUSE OF DEATH <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CVA</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days.</i> <i>years.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>this hospital</i> attended the deceased from <i>3/20</i> 19 <i>67</i> to <i>3/22</i> 19 <i>67</i> , that (I) <i>we</i> lost the deceased alive on <i>3/22</i> 19 <i>67</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>We</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>David Swimmer</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/22/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. David Swimmer</i>		23D. ADDRESS M.D. <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-24-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
24G. FUNERAL DIRECTOR <i>Charles R. Law</i>		24H. ADDRESS <i>802 Madison Ave.</i>			



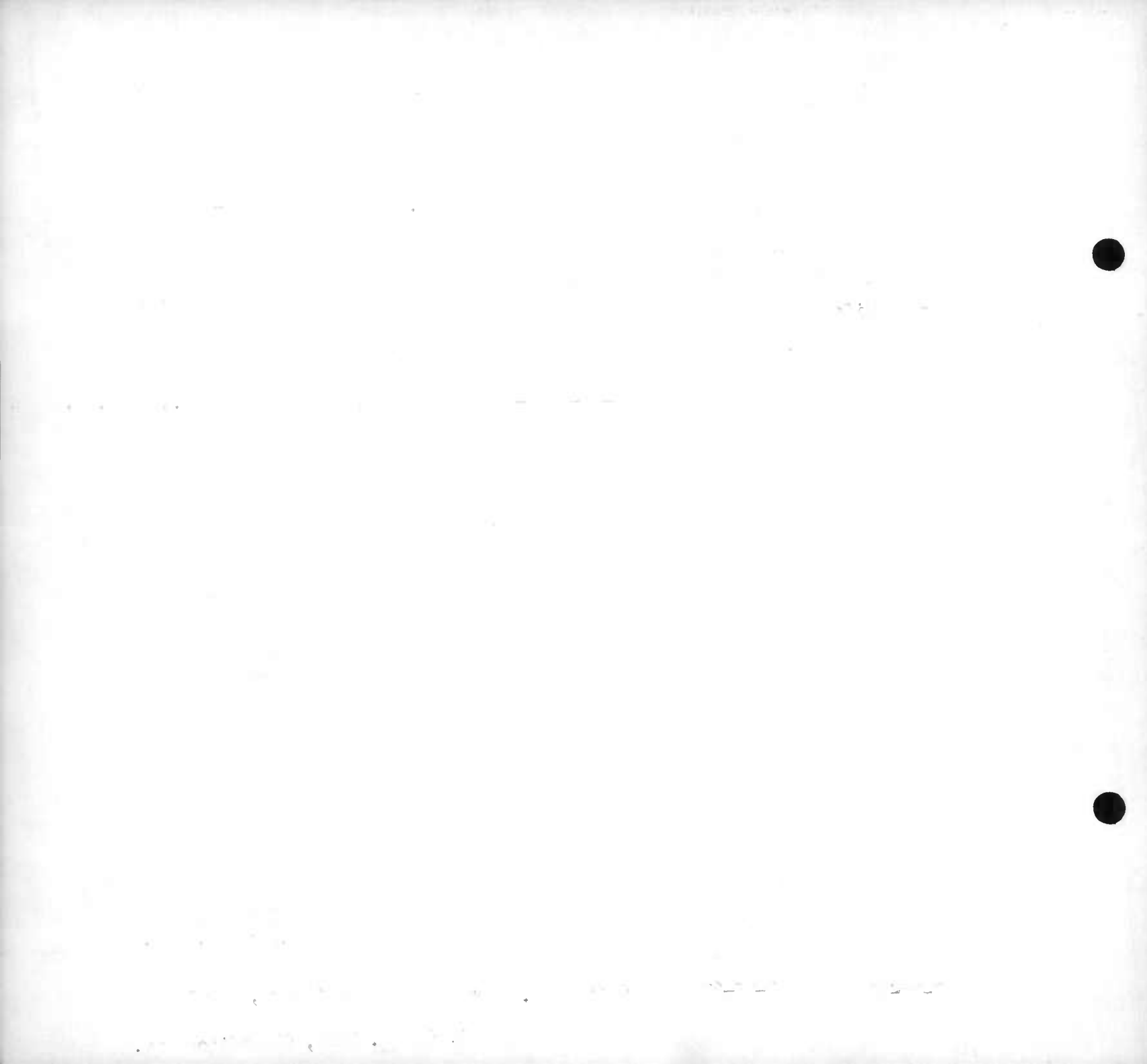
B-300

BIRTH NO. 67 2910		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) BLANCHE BOYD		2. DATE AND HOUR PRONOUNCED DEAD 3-21-67 10:37 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1012 Mt. Holly Street 21229	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-28-1937
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 29
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS William F. Powell, 2626 Boone St.	
18. 2951X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Gunshot wound of head DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Porch of 1771 Homestead Street	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) 3 21 '67 8:10 PM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> Shot in head	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-22-67 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-25-67	
23C. NAME of CEMETERY or CREMATORY Mt. Auburn		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		24B. NAME OF REGISTRAR Robert E. Fisher	
24C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.		ADDRESS	

VS 151-REV. 1/1/65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2911				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2911	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Phillips, Eugenia</i>				2. DATE AND HOUR OF DEATH <i>3/22/67 12 20 A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 15-04</i>			
				D. STREET ADDRESS (If rural, give location) <i>2004 N. Bentalou Street - 21217</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/29/87</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>ALABAMA</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>ALFRED F. NIXON</i>				
14. MOTHER'S MAIDEN NAME <i>NETTIE R. CLAYTON</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <i>579-62-8380-T</i>			17. INFORMANT ADDRESS <i>RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224</i>				
18. <i>420.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>ASCVD</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ASHD</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Years</i> <i>Years.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1/24</i> 19 <i>67</i> to <i>3/22</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/21</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>David Swimmer</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/22/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>DAVID SWIMMER</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto., Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-25-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>		25B. NAME OF REGISTRAR <i>Charles E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law, 802 Madison Ave.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2912	
BIRTH NO. 67 2912		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED ANNIE SIMON		2. DATE AND HOUR OF DEATH MARCH 23, 1967	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2111 McCULLOH STREET		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2111 McCULLOH ST.	
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH AUG. 23, 1899	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) REISTERSTOWN, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE W. BENNETT		14. MOTHER'S MAIDEN NAME RUTH THOMPSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT DONALD SIMON - 2111 McCULLOH ST.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 4-20-1 Myocardial Infarction Hypertensive Cardiovascular Disease Dissection		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2-78			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-21-1965 to 3-23-1967 , that (I) (we) last saw the deceased alive on 3-23-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald Simon M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3/24/67	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips		23D. ADDRESS M.D. 558 McMillan St. Balto Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-28-67		24C. NAME OF CEMETERY or CREMATORY ST. LUKES	
24D. LOCATION REISTERSTOWN, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR CHARLES R. LAW	
25D. ADDRESS 802 MADISON AVE.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
M-610		67 2913		67 2913	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Amelia Murphy		3-19-67 9:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
43 South Baltimore General Hosp.		Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore #21224-01			
D. STREET ADDRESS (If two, give location)		2800 Dillon St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F.	White	Widow	2-4-92	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tacker				Baltimore, Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Joseph GREEN		ANNA Davis			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
212-01-6460		Mrs. Alverta Reina - 2800 Dillon Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) AA CHF		2 hr	
ANTECEDENT CAUSES		(B) MI + pulmonary infarct		10 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) thromboembolic R. leg			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that the (this hospital) attended the deceased from 3-4 19 67 to 3-19 19 67, that the (we) last saw the deceased alive on 3-19 19 67 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Richard Reed				3-20-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Richard Reed		1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3-23-67		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 27 1967		Robert E. Jenkins		John C. Miller Inc-6415 Belair Road-21206	
25D. LOCATION (City, town, or county) (State)		Baltimore, Maryland			

End of year 1914
July 1st

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2914		CERTIFICATE OF DEATH		Registered No. 67 2914	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) GEORGE E. POWER			3/20/67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) KENESAW CONV. HOME 2601 ROSLYN AVE			A. STATE MD. B. COUNTY BALTO. Co.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 53-00		
			D. STREET ADDRESS (If rural, give location) 24 CEDARWOOD Rd.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	B. DATE OF BIRTH 6/4/80	9. AGE (In years lost-birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY RET.	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE A. POWER			14. MOTHER'S MAIDEN NAME ALICE Lisle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217265438	17. INFORMANT READ H. POWER		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arterio Sclerotic Cardio Vascular and Cerebro Vascular Disease			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Semility		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1967 to March 20th 1967 , that (I) (we) last saw the deceased alive on March 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M Paul Byerly			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/21/67
23C. PHYSICIAN'S NAME (Type) M Paul Byerly			23D. ADDRESS 5820 York Rd		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/23/67		24C. NAME OF CEMETERY or CREMATORY WESTERN	
24D. LOCATION BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR E. S. MAGNABB		25D. ADDRESS 301 FREDERICK RD 21228	

Handwritten notes, possibly a list or ledger, with multiple lines of text. The text is mostly illegible due to fading and bleed-through from the reverse side of the page. Some words like "List" and "Notes" are faintly visible.

Handwritten notes at the bottom of the page, including what appears to be a signature or name "W. H. Smith" and other illegible text.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

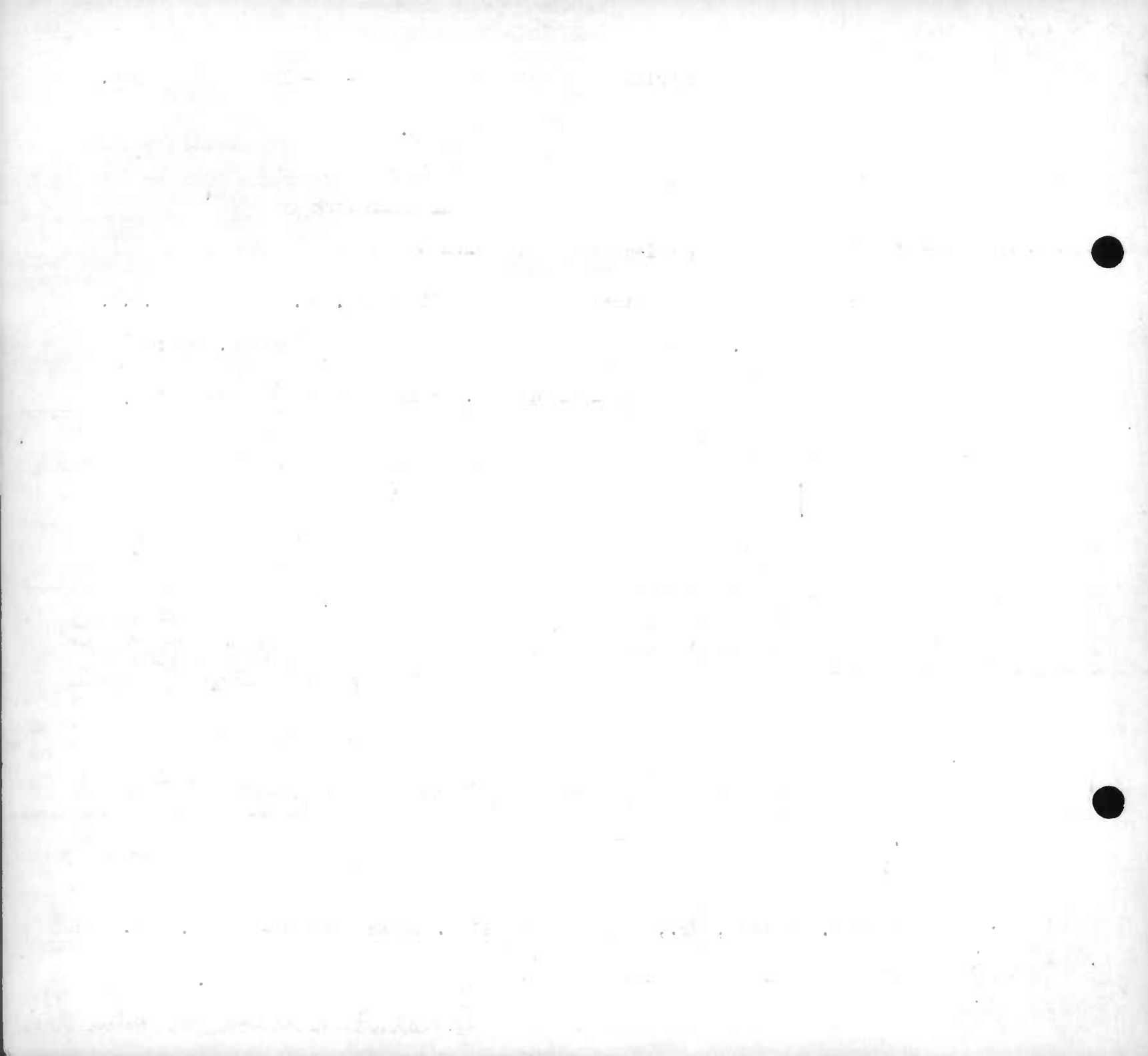
BIRTH NO. 67 2915		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2915	
M.E. CASE NO.		1. NAME OF DECEASED Robert L. Pruitt		2. DATE AND HOUR OF DEATH 3/20/67 1050 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 10418 Reisterstown Rd Balt Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Reisterstown Md. 53-00 D. STREET ADDRESS (If rural, give location) Balt. Co.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1/19/13	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckdriver		10B. KIND OF BUSINESS OR INDUSTRY W.D. Groff Co.		11. BIRTHPLACE (State or foreign country) Chilhowie, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Pruitt		14. MOTHER'S MAIDEN NAME Nannie Dillon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-20-2763		17. INFORMANT Mrs. Lillian B. Pruitt	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Ventricular Fibrillation (B) Myocardial Infarction (C) ASCVD INTERVAL BETWEEN ONSET AND DEATH 50 min 2 hr.		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) 22. I certify that (H) (this hospital) attended the deceased from 3/20/67 19 to 3/20/67 19, that (I) (we) last saw the deceased alive on 3/20/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		23A. SIGNATURE B. J. Baldwin M.D. 23B. DATE SIGNED 3/20/67		23C. PHYSICIAN'S NAME (Type) BRIAN J. Baldwin M.D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/67		24C. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens	
24D. LOCATION Finksburg, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR R. E. Finkbeiner	
25C. FUNERAL DIRECTOR H. J. Eglhardt		25D. ADDRESS Owings Mills, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2916	
BIRTH NO. 67 2916		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Olive Gambrill		3- 21- 1967 2 A.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 2942 Wyman Parkway			A. STATE Md. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2942 Wyman Parkway		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5-4-1888	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John R. Moore			
14. MOTHER'S MAIDEN NAME Annie C. Gambrill		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 320-36-9011		17. INFORMANT Townson 4 E. Scott Moore 408 Jefferson Bldg.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Cerebral Thrombosis, recurrent arteriosclerosis (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH 2 days			6 years.		
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-23-66 to 3/21/67, that (I) (was) last saw the deceased alive on 3/18/67, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (not) view the body after death.					
23A. SIGNATURE W.B. Daniels, Jr.			23B. DATE SIGNED 3/21/67		
23C. PHYSICIAN'S NAME (Type) Worth B. Daniels, Jr.,			23D. ADDRESS 11 E. Chase Street - Balto., Md. 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-1967		24C. NAME of CEMETERY or CREMATORY Camp Chapel Cemetery	
24D. LOCATION Baltimore Co. Md		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2917				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2917	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARRY W. SMITH				2. DATE AND HOUR OF DEATH March 24, 1967		4:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convalesarium				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3113 Dillion Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 4, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Rose Schmidt				
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 213-07-2988			17. INFORMANT Mrs. Marie R. Smith ADDRESS 3113 Dillion Street				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3/22/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/20 19 67 to 3/24 19 67 , that (I) (we) last saw the deceased alive on 3/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert E. May				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/27/67	
23C. PHYSICIAN'S NAME (Type) ROBERT E. MAY				23D. ADDRESS 5662 THE ALAMEDA			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-28-1967		24C. NAME of CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. May		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

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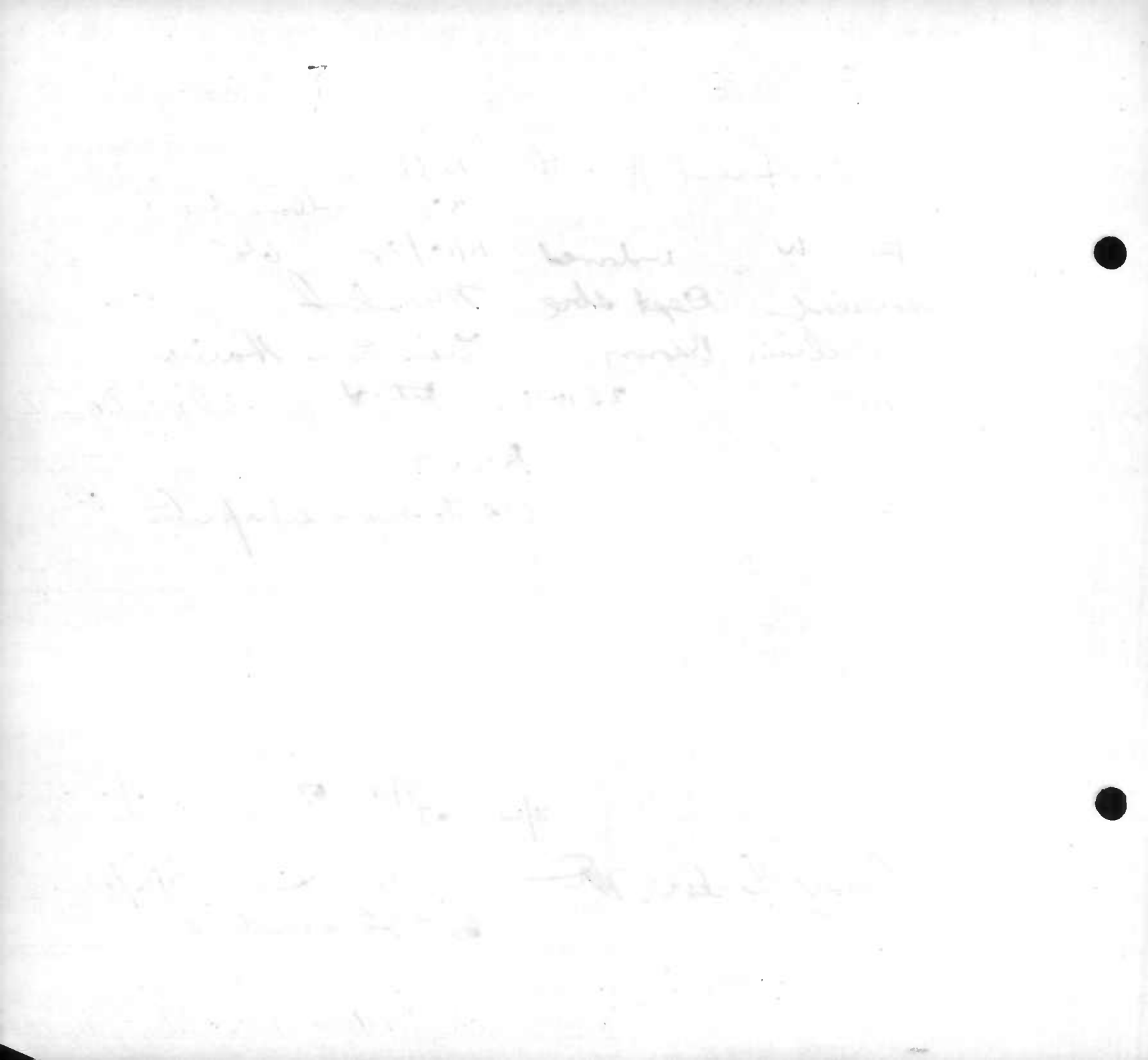
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2918		CERTIFICATE OF DEATH		Registered No. 67 2918	
1. NAME OF DECEASED (Type or Print) GRETTA F. BAIR				2. DATE AND HOUR OF DEATH 3/26/67 11:20 AM.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital 48				4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 28-41 D. STREET ADDRESS (If rural, give location) 3904 Woodbine Ave					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) unwed	8. DATE OF BIRTH 12/20/98		9. AGE (In years last birthday) 68		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sales		10B. KIND OF BUSINESS OR INDUSTRY Dept. store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Brown			14. MOTHER'S MAIDEN NAME Elsie Emma Haines						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-10-1952		17. INFORMANT ROGER L. BAIR - 2 PARK DR #7				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO		(B) DUE TO			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3/18/67 to 3/26/67 , that (I) (we) last saw the deceased alive on 3/26/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Donald F. ...						23B. DATE SIGNED 3/26/67			
23C. PHYSICIAN'S NAME (Type) M.D.						23D. ADDRESS 427 Linden Ave			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-28-67		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Charles ...		25D. ADDRESS 4600 Liberty Heights Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-25-66-1B		BIRTH NO. 67 2919		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2919	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Clarence Matthews</i>				2. DATE AND HOUR OF DEATH <i>3/21/67 12:45 A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</i>						A. STATE <i>MARYLAND</i> B. COUNTY <i>10-02</i>			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
						D. STREET ADDRESS (If rural, give location) <i>608 E. MADISON ST. #21202</i>			
5. SEX <i>MALE</i>		6. RACE <i>NEGRO</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>SINGLE</i>		8. DATE OF BIRTH <i>7-9-02</i>		9. AGE (In years lost birthday) <i>64</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>			
13. FATHER'S NAME <i>JOHN</i>				14. MOTHER'S MAIDEN NAME <i>NEBRON</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>#21224</i>		ADDRESS <i>RECORDS-BCH-4940 EASTERN AVENUE</i>	
18. <i>177X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CA of prostate</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						(B) DUE TO			
						(C) DUE TO			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/19 66</i> to <i>3/21 67</i> , that (I) (we) last saw the deceased alive on <i>3/21 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Franklin G. Strauss</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <i>3/21/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Franklin G. STRAUSS</i> M.D.						23D. ADDRESS <i>BCH #21224 4940 EASTERN AVENUE</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/27/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>		ADDRESS <i>1206 W North Ave</i>			

CP of James

BCH

Franklin C. Johnson
March 20, 1900

48-23-06-1
W.6/14

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2920		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2920	
M.E. CASE NO. 48-93-06		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William Warfield		2. DATE AND HOUR OF DEATH 3/24/67 1 7 ⁵⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		A. STATE Maryland B. COUNTY Baltimore			
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower	
8. DATE OF BIRTH 2-23-96		9. AGE (In years lost birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Warfield	
14. MOTHER'S MAIDEN NAME Fannie Rhodes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BCH: Records		ADDRESS Baltimore, Maryland 4940 Eastern Ave. #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) DUE TO infection & starvation & airway obstruction		many mos	
		(B) DUE TO recurrence of squamous cell ca following radical neck dissection			
		(C) DUE TO sq. ca - base of mouth		1.8 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes mellitus			
19A. DATE OF OPERATION 2/7/19/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED squamous ca of base of mouth		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/23/67 19 67 to 3/24 19 67, that (1) (we) last saw the deceased alive on 3/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ann Louise Silver		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/24/67	
23C. PHYSICIAN'S NAME (Type) Ann Louise Silver		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/29/67		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION A A County Md		25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 2921	
BIRTH NO. 67 2921		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) White, Daisy		2. DATE AND HOUR OF DEATH 9.45 pm - March 20, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 12-03			
5. SEX F		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W		8. DATE OF BIRTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Agnes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 055-22-7419		17. INFORMANT Chart			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ca of breast. E Metastasis to lung				INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10.20 pm - March 19 1967 to 9.45 pm March 20 1967 , that (I) (we) last saw the deceased alive on 9.45 pm March 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sang Won Song				23B. DATE SIGNED March 20, 1967			
23C. PHYSICIAN'S NAME (Type) SANG WON SONG,				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Adolphus Halstead			
				ADDRESS 1206 W North Ave			



48-76-39 1B

67 2922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2922

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James Robertson

2. DATE AND HOUR OF DEATH

3-23-67

12:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2345 EUTAW PLACE

#21217

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

3-4-15

9. AGE (In years
lost birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MAJOR

14. MOTHER'S MAIDEN NAME

MARY JANE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

#21224

ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Carcinoma of the Pancreas

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

Months Known

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 2-25-67 to 3-23-67
that (H) (we) last saw the deceased alive on 3-22-67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Mishelevich

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3-25-67

23C. PHYSICIAN'S
NAME (Type)

DR. DAVID J. MISHELEVICH

M.D.

23D. ADDRESS

#21224

BCH-4940 EASTERN AVENUE, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/26/67

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION

Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAR 27 1967

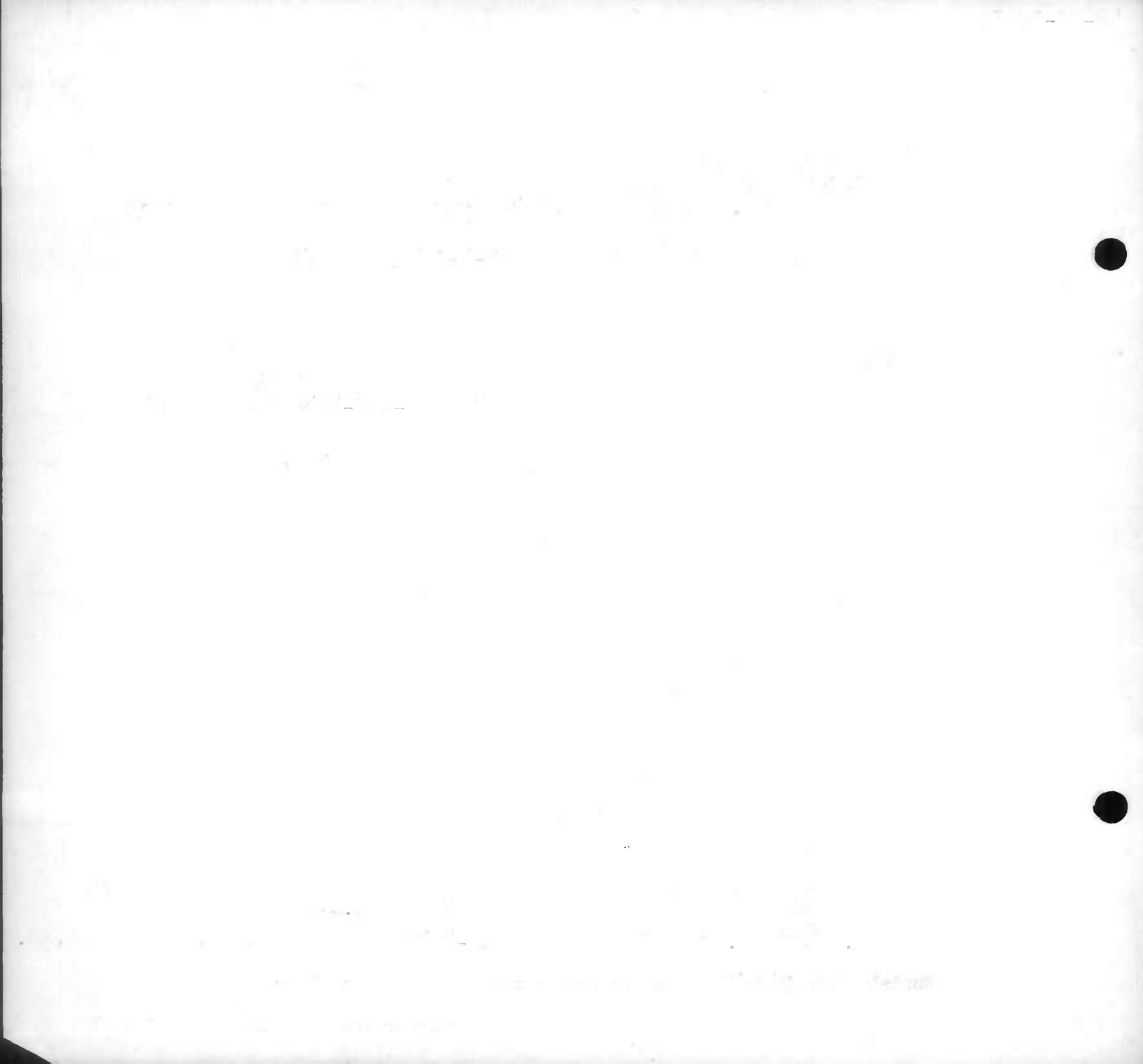
Robert E. Farley

Adolphus Halstead 206

W North Ave

FUNERAL DIRECTOR: IMPORTANT

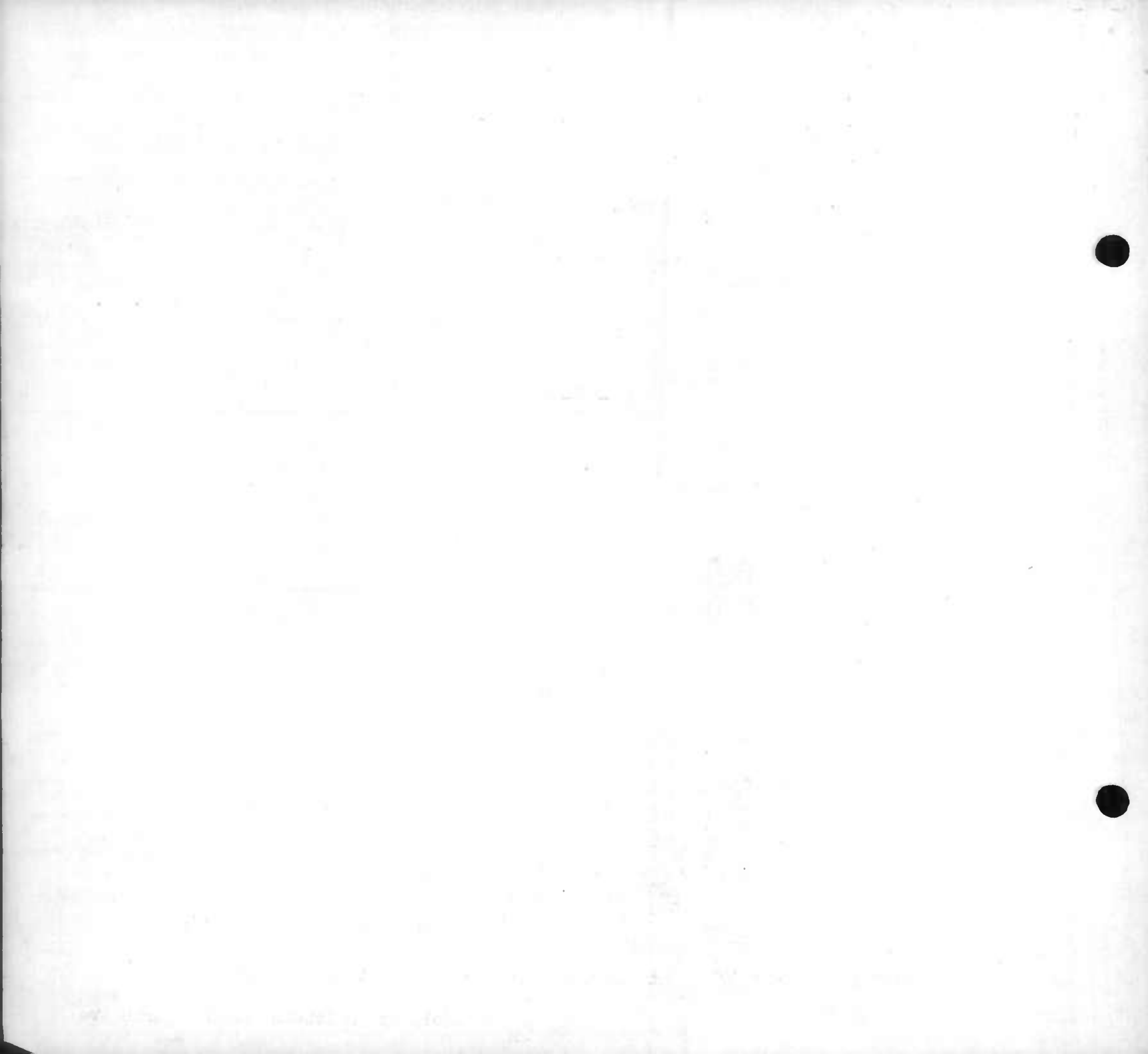
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

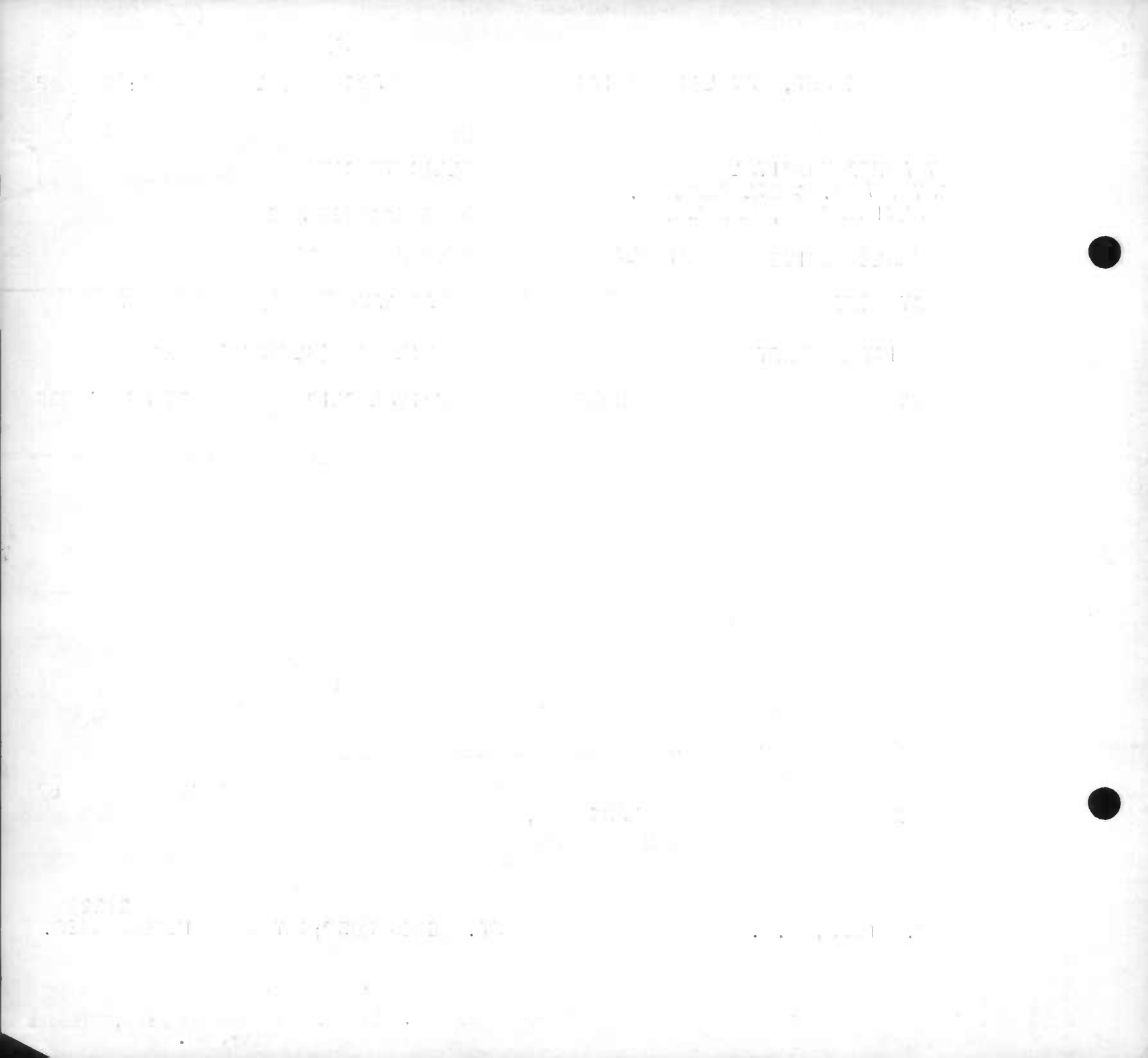
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2922	
BIRTH NO. 67 2922		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Theodore Waters		2. DATE AND HOUR OF DEATH 3/17/67 9:30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1602 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1313 MOSHER STREET 21217		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-5-13	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) FLORIDA		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-03-8722HA	17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Respiratory arrest - DUE TO (B) Metastatic carcinoma DUE TO (C) of the lung - CKA's		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/23 19 66 to 3/17 19 67 , that (I) (we) last saw the deceased alive on 3/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Terry Ersel Gagon M.D.				23B. DATE SIGNED 3/17/67	
23C. PHYSICIAN'S NAME (Type) TERRY ERSEL GAGON				23D. ADDRESS M.D. 4940 EASTERN AVENUE 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md					
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2924	
BIRTH NO. 67 2924		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KUNST, KATHLEEN DENISE		2. DATE AND HOUR OF DEATH MARCH 22, 1967 9:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Howard Co.			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON AVE. & WILKENS AVE. BALTIMORE 29, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY 63-00			
D. STREET ADDRESS (If rural, give location) 46 EVERGREEN AVE		5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH 2/19/51 9. AGE (In years last birthday) 16	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME VICTOR KUNST		14. MOTHER'S MAIDEN NAME MILDRED (GLENSKY) KUNST	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS HOSPITAL SLIP ST AGNES HOS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 204.31 ACUTE MYELOGENOUS LEUKEMIA		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 3/21/67 19 67 to 3/22 19 67, that (X) (we) lost saw the deceased alive on MARCH 22, 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. DIBOS		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) P. DIBOS, M.D.		23D. ADDRESS ST. AGNES HOSP; CATON & WILKENS AVES.		21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAR 27 1967		24F. NAME OF REGISTRAR Robert E. Fisher	
24G. FUNERAL DIRECTOR Harry H. Witke		24H. ADDRESS 321 Columbia Pike, Ellicott City, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2925	
BIRTH NO. 67 2925		CERTIFICATE OF DEATH		Registered No. 67 2925	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DANIEL T. TAYLOR SR.		2. DATE AND HOUR OF DEATH 3-24-67 8:02 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 323 HIGH FALCON RD.			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSP.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-31-06	9. AGE (In years lost birthday) 60	10. CITIZEN OF WHAT COUNTRY? U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME JAMES W. TAYLOR		14. MOTHER'S MAIDEN NAME SARA E. BONER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-07-1489		17. INFORMANT ADDRESS HOSP. CHART.	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MIDDLE CEREBRAL A. THROMBOSIS		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 48 HRS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3-22-67 to 3-24-67 , that (2) (we) lost saw the deceased alive on 3-23-67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin Schachter M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3-24-67	
23C. PHYSICIAN'S NAME (Type) ALVIN SCHACHTER M.D.		23D. ADDRESS SINAI HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-27-67		24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY	
24D. LOCATION (City, town, or county) (State) PIKESVILLE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St.	

3-22-52

MD. BALT.

BALTIMORE

333 HIGHWAY RD

MARRIED 3-21-52

BALTIMORE

POST OFFICE

CHIEF CLERK
THOMAS

3-22-52

3-22-52

3-22-52

3-22-52

3-22-52

3-22-52

3-22-52

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2926		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2926	
M.E. CASE NO.		1. NAME OF DECEASED <i>Otto Paul Hoffman</i>		2. DATE AND HOUR OF DEATH <i>3/22/67 4:25 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore County</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Cockeysville 53-00</i> D. STREET ADDRESS (If rural, give location) <i>Masonic Home</i>			
5. SEX <i>M</i>	6. RACE <i>Caucasian</i>	7. MARRIED NEVER MARRIED <i>WIDOWED</i> DIVORCED (specify)	8. DATE OF BIRTH <i>08/08/90</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Theodore Hoffman</i>			14. MOTHER'S MAIDEN NAME <i>Bertha Nisei He</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-01-8252</i>		17. INFORMANT ADDRESS <i>Mrs. Earl McQuay</i>	
18. <i>153.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cancer of Sigmoid Colon</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>3 Months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/16/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of Colon</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>3/19</i> 19 <i>67</i> to <i>3/22</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>3/22</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles H. Clason, Jr.</i> M.D. 23C. PHYSICIAN'S NAME (Type) <i>CHARLES H. CLASON, JR.</i>				23B. DATE SIGNED <i>3/22/67</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3-25-67</i>		24C. NAME of CEMETERY or CREMATORY <i>LODSON PARK</i>	
24D. LOCATION (City, town, or county) <i>BALTIMORE MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>WM COOK-BROOKS TOWSON TOWSON MD</i>			

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2927**

BIRTH NO. **67 2927**

M.E. CASE NO. **67 2927**

1. NAME OF DECEASED (Type or Print) **FRELL CROCKETT**

2. DATE AND HOUR PRONOUNCED DEAD **March 24, 1967 8:15 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Lutheran Hospital (DOA)**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Maryland** B. COUNTY **16-07**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **3119 W. Baker St.**

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH **Nov. 12, 1892** 9. AGE (In years lost birthday) **74** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Librarian - Baltimore Public Library**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Rock Hill S.C.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Paul Crockett** 14. MOTHER'S MAIDEN NAME **Allen Smith**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO.

17. INFORMANT **Flora Crockett 3119 W. Baker St.** ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Arteriosclerotic heart disease**

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES **(A) DUE TO**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. **(B) DUE TO**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **(C)**

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **3-25-67**

EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **March 24, 1967** 23C. NAME OF CEMETERY or CREMATORY **Mount Calvary Cem.** 23D. LOCATION (City, town, or county) (State) **A. A. County Md.**

24A. DATE REC'D BY HEALTH DEPT. **MAR 27 1967** 24B. NAME OF REGISTRAR **Robert E. Finkbeiner** 24C. FUNERAL DIRECTOR **Joseph T. Erickson** ADDRESS **1297 N. Carey St.**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2928				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2928	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret Johanna Bopp				2. DATE AND HOUR OF DEATH March 26, 1967 3:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore			
5. SEX Female				6. RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married WIDOWED				8. DATE OF BIRTH 5-24-1894			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Pennsylvania			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Peter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.			
17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224				ADDRESS			
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Sepsis				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO UTS, fecal impaction Diabetes Mellitus			
INTERVAL BETWEEN ONSET AND DEATH 3 days				5 years			
19. DATE OF OPERATION 2				20A. AUTOPSY? (Yes or No) YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19-1-19 58 to 3/26 19 67. that (I) (we) last saw the deceased alive on 3/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Bruce M. Dow M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stok Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED 3/26/67			
23C. PHYSICIAN'S NAME (Type) Dr. Bruce M. Dow				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3/29/67			
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore			
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967				25B. NAME OF REGISTRAR Robert E. Taylor			
25C. FUNERAL DIRECTOR Leo Cook				25D. ADDRESS 7200 Harford Road			

V. a.

2 pages

U.S. 2, 1900, 270
Baltimore, Md.

3/10/00

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3/10/00

3/10/00

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0

0

James M. Davis

x

1/10/00

3/10/00

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

John RUDY YOUNG

2. DATE AND HOUR PRONOUNCED DEAD

March 24, 1967 8:05 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

554 Roberts Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
never married

8. DATE OF BIRTH

March 11, 1967

9. AGE (in years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

14

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Rudolph

14. MOTHER'S MAIDEN NAME

Roslyn Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
none

17. INFORMANT

ADDRESS

Cathline Harris 554 Robert St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Interstitial Pneumonitis. (SDII)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/24/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-27-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 27 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS

1
VALLEY PRINCE
RECORDS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2930		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2930	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>Loletta-Challoner- LOLETTA CHALLONER</u>		
2. DATE AND HOUR OF DEATH 3/24/67 9:45 a.m.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Bolton Hill Nursing Center (21217) FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4009 Keswick Road		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7/6/88-7/6/88	9. AGE (In years lost birthday) 79 78	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked		10B. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Thomas Challoner			14. MOTHER'S MAIDEN NAME Mary Meridith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 18-4-2783	17. INFORMANT ADDRESS Mrs. M.G. Waters (niece) 4009 Keswick--21211		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 204.4 + E 9030 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <u>Pneumonia</u> (B) <u>fractured pelvis</u> (C) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>1 week</u> <u>days</u>	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4009 Keswick Rd 4019 Keswick Rd	
21D. TIME OF INJURY (APPROX.) 3/16/67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall off the building due to equipment	
22. I certify that (I) (this hospital) attended the deceased from 3/21 1967 to 3/24 1967. that (I) (we) lost saw the deceased alive on 3/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>allan H. Macht</u> M.D.				23B. DATE SIGNED 3/24/67	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.				23D. ADDRESS 2 EAST READ ST.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE Mar-29-67		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md. 21229		24E. DATE REC'D BY HEALTH DEPT. MAR 27 1967			
25A. NAME OF REGISTRAR P. E. E. E. E.		25B. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co. 108-W-North-Av. 21201			

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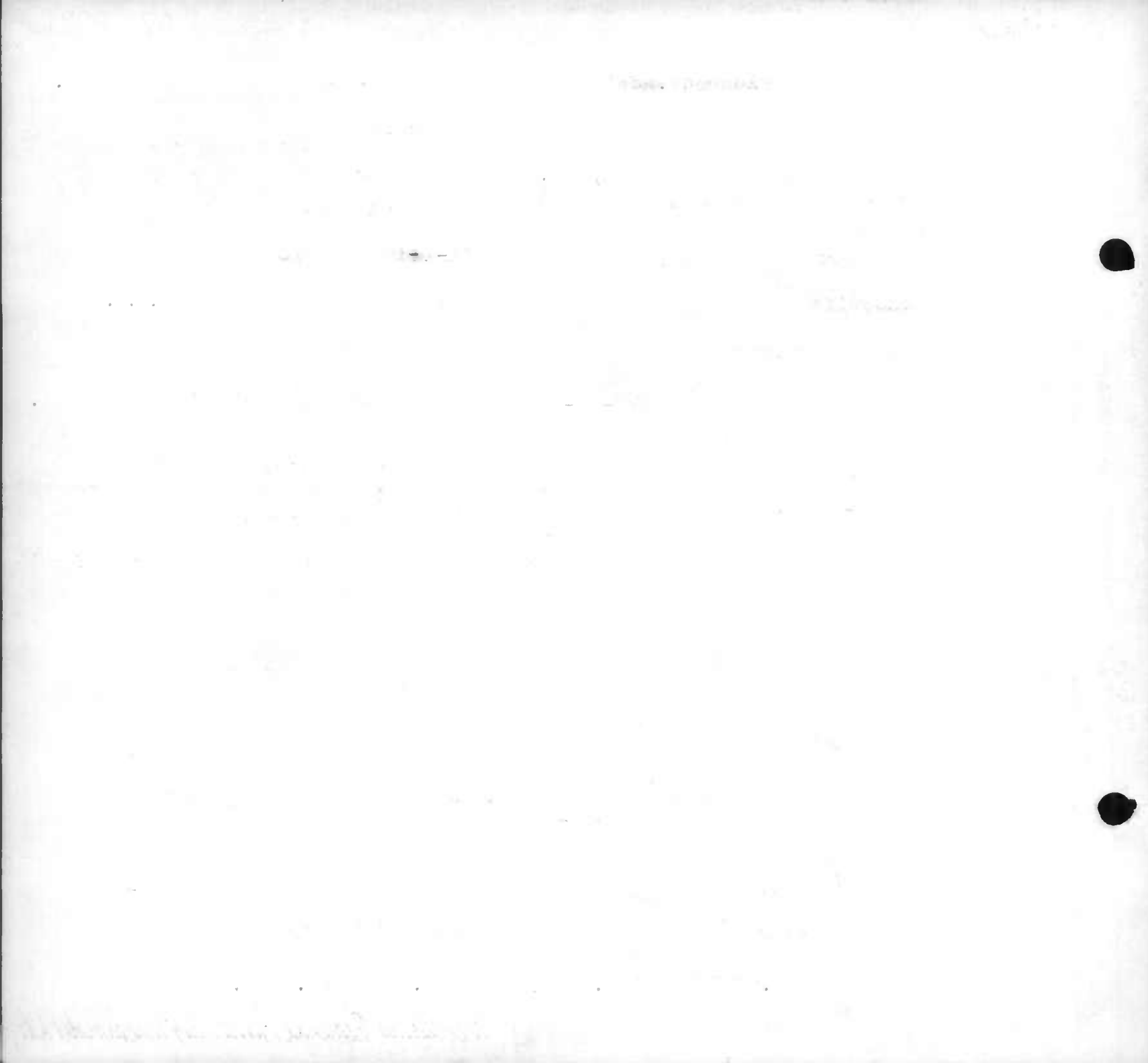
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 2931	
BIRTH NO. 67 2931		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Flournoy, Rosie				2. DATE AND HOUR OF DEATH 3-24-67 3:20 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital, Inc. Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1501 Dukeland Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-1-1896	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Hargrove			14. MOTHER'S MAIDEN NAME Mary				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-24-3354		17. INFORMANT Robert Flournoy (Son)			ADDRESS 1422 Mulberry St.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 199.2.1 Hypostatic bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic carcinoma to lumbar, paraortic, peripancreatic L.V.				INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-26-67 to 3-24-67 and that (I) (we) last saw the deceased alive on 3-24-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Setaurban				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-25-67	
23C. PHYSICIAN'S NAME (Type) Setaurban		23D. ADDRESS 1514 Division Street					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar. 29/67		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 399 N. Chardon St.	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AMOS

JONES

2. DATE AND HOUR PRONOUNCED DEAD

March 24, 1967

9:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

928 N. Bond St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sept 20

9. AGE (In years
lost birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Watonka, Pa

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Jones

14. MOTHER'S MAIDEN NAME

Shattii Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

228-07-5951

17. INFORMANT

Amos L. Jones

ADDRESS

18.

E919.31

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of trunk
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

900 Block N. Bond Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3-24-67 9:15 P. m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Dropped gun which discharged

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-30-67

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION (City, town, or county)

Balto

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 27 1967

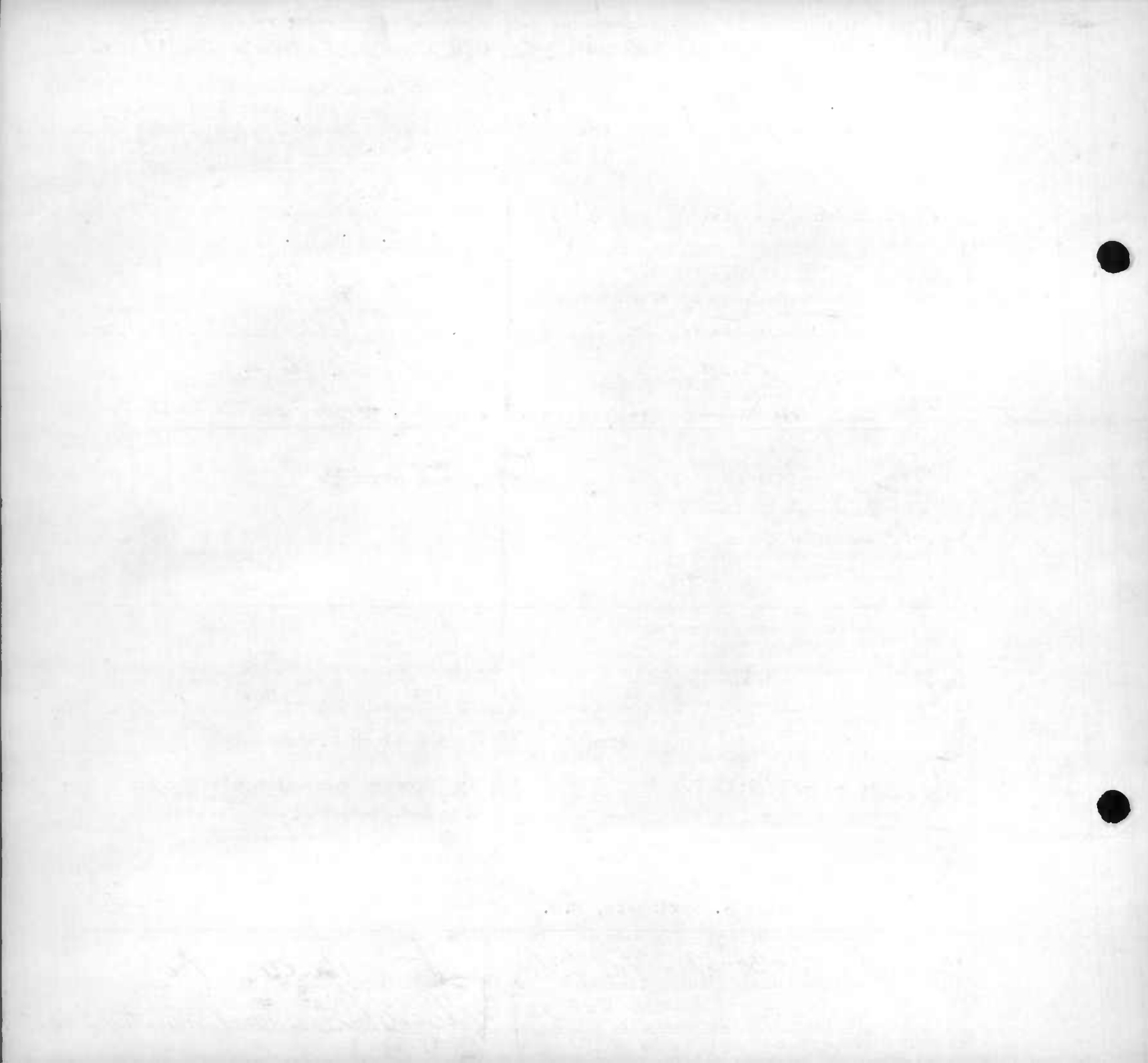
24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Clary Wilson or Brentley

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2933	
BIRTH NO. 67 2933		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Walter Murray		2. DATE AND HOUR OF DEATH 3/23/67 8:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1217 East Prdston Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 11/20/08	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labr		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) a. a. C. mel	
13. FATHER'S NAME Charles Murray		14. MOTHER'S MAIDEN NAME Emma Willis		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Day ADDRESS Seven Park Mel	
18. 05341 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Klebsiella Pneumonia + Sepsis.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/20 1967 to 3/23 1967 , that (I) (we) last saw the deceased alive on 3/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W S Wilson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/23/67	
23C. PHYSICIAN'S NAME (Type) W Stan Wilson		23D. ADDRESS J H H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-29-67		24C. NAME OF CEMETERY OR CREMATORY Inter-Oakland Cent	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE RECEIVED BY HEALTH DEPT. MAR 27 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Chas Wilson ADDRESS 1000 P. Rowley St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2934	
BIRTH NO. 67 2934		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Willard SMITH		2. DATE AND HOUR OF DEATH March 25, 1967 2¹⁰ Am M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1 BALTIMORE CITY 21217 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1803 N. PAYSON ST		
5. SEX MALE	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 1/28/58	9. AGE (In years lost birthday) 9	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Bethesda Md		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Lawrence Smith			14. MOTHER'S MAIDEN NAME Anna Hendrickson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Anna Smith Same		
18. 204.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ARRHYTHMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? LEUKEMIC HEART INFILTRATES LEUKEMIA (MONO-MYELOCYTIC)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN 2 19 67 to MARCH 25 19 67 , that (I) (we) last saw the deceased alive on MAR 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Norman Fost				23B. DATE SIGNED Mar 25 '67	
23C. PHYSICIAN'S NAME (Type) NORMAN FOST				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-28-67		24C. NAME OF CEMETERY or CREMATORY mt Antone Cml	
24D. LOCATION (City, town, or county) (State) Balto Md					
25A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Thompson 1001 B. County Rd	

JOHN HOPKINS HOSPITAL

1803 N. PAVAN ST

M N NEVER MARRIED 1/8/28 P

Anna

ARR YTHIA

LEUKEMIC HEART INFARCTED

LEUKEMIA (MONO-MYELOCYTIC)

NORMAN FOST
NORMAN FOST

JOHN HOPKINS HOSPITAL
MAR 25 1928

MAR 25 1928
JAN 2 1928

67

MAR 25 1928

X

MAR 25 1928

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2935	
BIRTH NO. 67 2935		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Maige Murray</i>		2. DATE AND HOUR OF DEATH <i>March 25 1967 8:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home & Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Harford</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Maryland</i> D. STREET ADDRESS (If rural, give location) <i>1542 N. Washington St</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>1-14-24</i>	9. AGE (In years lost birthday) <i>43</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Part-time domestic work</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Michigan</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Andrew Murray</i>			14. MOTHER'S MAIDEN NAME <i>Agnes Smith</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Agnes Smith</i>	
18. <i>44-5X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebrovascular Accident</i> DUE TO (B) <i>Hypertensive cardiac-vascular disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/24/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Respiratory exam</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/21</i> 19 <i>67</i> to <i>3/25</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. C. HARIANO</i>				23B. DATE SIGNED <i>3-25-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. C. HARIANO</i>		23D. ADDRESS <i>CHURCH HOME & HOSPITAL BALTIMORE, MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-24-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Annum Cent</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Chas. J. Wilson 1000 Brantley Ave</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No.	
BIRTH NO. 67 2936						67 2936	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Anthony R. Hollie		March 22, 1967 10:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
39 Provident Hospital, Inc.		1514 Division Street		Maryland			
		Baltimore, Maryland 21217		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore, 1501	
				D. STREET ADDRESS (If rural, give location)		1605 Spray Court Apt. 3	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Male	Negro	Separated	8-17-07	59 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				Maryland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Hollie				Nora Cole			
15. Was deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		218-03-5234		Pauline Lewis - daughter		325 E. 21st. St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO				Congestive Heart Failure	
ANTECEDENT CAUSES		(B) DUE TO				Cancer of Prostate	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from February 25, 1967 to March 22, 1967, that (I) (we) last saw the deceased alive on March 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)						2-24-67	
				23D. ADDRESS			
				M.D. 1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3-27-67		Mt Auburn Cem		Balto Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 27 1967		Robert E. Taylor		Clay Wilson		1000 Prentiss Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2937	
BIRTH NO. 67 2937		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Newman Charles</i>		2. DATE AND HOUR OF DEATH <i>12¹⁰ AM 3-24-67 M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY	
<i>31</i> <i>Baltimore City Hospitals</i> <i>4040 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location)		<i>Hospitals</i> <i>4940 Eastern Ave., Baltimore City</i>	
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>2/28/1900</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas Newman</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn Lee</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>BCH-4940 Eastern Avenue (Records)</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) <i>Cardiac Arrest</i> (B) <i>? Arrhythmia</i> (C) <i>Menigeovascular Syphilis</i>		<i>4 days</i> <i>7 15 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from <i>1-31</i> 19 <i>38</i> to <i>3-24</i> 19 <i>67</i> , that (if) (we) last saw the deceased alive on <i>3-24</i> 19 <i>67</i> and that in (if) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A.P. Weinfeld</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-24-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>A.P. WEINFELD</i>		23D. ADDRESS M.D. <i>4940 EASTERN AVENUE, BALTIMORE, MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-28-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn Cml</i>	
24D. LOCATION (City, town, or county) <i>Balto</i>		(State) <i>MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 27 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>Charles W. Wexler 1000 Brantley Dr</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2938**BIRTH NO. **67 2938**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAULINE

COLEMAN

2. DATE AND HOUR PRONOUNCED DEAD

March 23, 1967

4:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

910 E. Preston Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct 10 - 1942

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Coleman

14. MOTHER'S MAIDEN NAME

Pauline Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Pauline Hamilton

ADDRESS

North Lane

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Gunshot Wound of Chest.

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

910 E. Preston Street

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3

23

'67

P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot self

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/24/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-28-67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cent

23D. LOCATION

(City, town, or county)

Brooklyn Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 27 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Eloy O. Wilson 1005 Grantley Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 2939		67 2939		67 2939	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				Hester Alice	
2. DATE AND HOUR OF DEATH		3/20/67 3:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Dulles Nursing Home		A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1717 E. 25th St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	negro	Widowed	3-16-1890	77	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		At home		Durham, N.C.	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Informant	
Dock Williams		Martha Witherspoon		Dulles Nursing Home	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. ADDRESS	
No		NONE		1501 Dulles Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CHRONIC MYOCARDITIS			
ANTECEDENT CAUSES		(B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-1-1966 to 3-20-1967, that (I) (we) last saw the deceased alive on 3-20-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Thomas W. Harris				3-20-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
THOMAS W. HARRIS		1824 W. FRANKLIN ST			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3-24-67		Gardens of Eternal Hope	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
Finksburg, Md.		2431 E. Oliver St.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 27 1967		Robert E. Jackson		Randolph J. Collick	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2940**BIRTH NO. **67 2940**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**LORENZO GRAVES**

2. DATE AND HOUR PRONOUNCED DEAD

3-22-67**7:15 AM**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**MERCY HOSPITAL - DOA**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE**Maryland**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 1016 E. Hoffman Street 21202

5. SEX

Male

6. RACE

Colored7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Married**

8. DATE OF BIRTH

12-22-19099. AGE (In years
last birthday)**57**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Long-shoreman**

10B. KIND OF BUSINESS OR INDUSTRY

Steamship Co.

11. BIRTHPLACE (State or foreign country)

Virginia12. CITIZEN OF
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

Henry**Graves**

14. MOTHER'S MAIDEN NAME

Eva Hall15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**NO**16. SOCIAL
SECURITY NO.**216-07-3134**

17. INFORMANT

Mrs Florine Graves 1016 E. Hoffman

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Hypertensive and arteriosclerotic****XXXX****cardiovascular disease**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) **DUE TO**(C) **OTHER**II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)**RUSSELL S. FISHER, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-22-6723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

3-25-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery Anne Arundel Co. Md.

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 27 1967

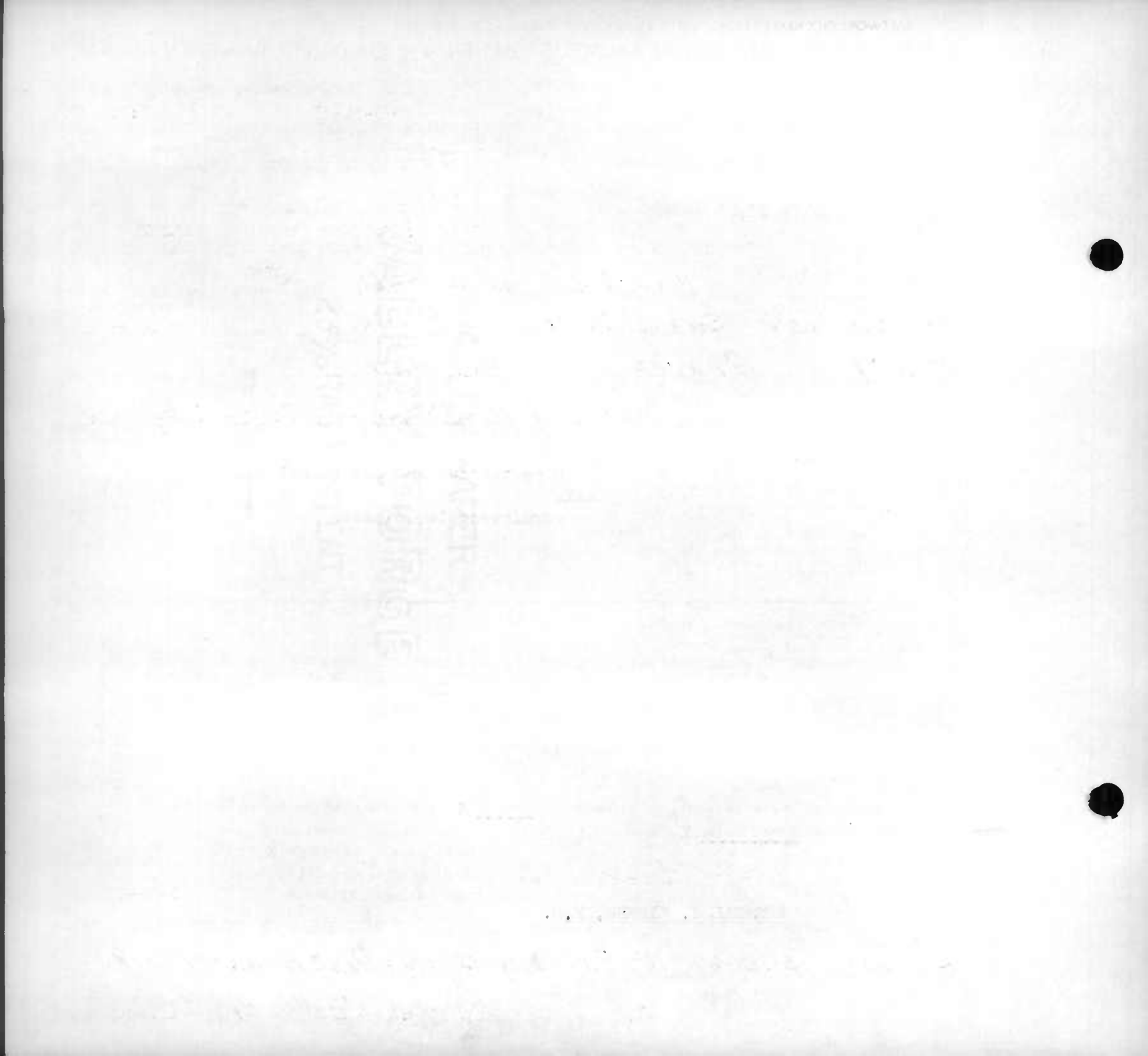
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Joseph J. Collick 2431 E. Oliver

ADDRESS



BIRTH NO. 67 2941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2941

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JOHN R. WILLIAMS				2. DATE AND HOUR PRONOUNCED DEAD March 24, 1967 9:25 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2744 E. Biddle St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2744 E. Biddle St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-10-1916	9. AGE (In years last birthday) 50	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY Smelting Co.		11. BIRTHPLACE (State or foreign country) Littleton, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alanzo Williams				14. MOTHER'S MAIDEN NAME Sallie Mills			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 238-208820		17. INFORMANT Mrs. Rosalie Williams 2744 E. Biddle St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Springate, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 3-25-67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-29-67		23C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		23D. LOCATION (City, town, or county) (State) Arbutus, Md.	
24A. DATE REC'D BY HEALTH DEPT. MAR 27 1967		24B. NAME OF REGISTRAR Robert E. Fasham		24C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.	

LET FORGET

20

4-10-1916

Received

Wm. C. Williams

Subscription

Salisbury Mills

Williams

Plaintiff

No.

Received 300.00 from Park Publishers, N.Y.

Wm. C. Williams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2942BIRTH NO. 67 2942M.E. CASE NO. M-320

1. NAME OF DECEASED (Type or Print) <u>Milton Edward Mattox</u>				2. DATE AND HOUR PRONOUNCED DEAD <u>March 17, 1967</u> <u>11:30 P.M.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-05</u> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>217 E. North Avenue</u>			
5. SEX <u>M.</u>	6. RACE <u>C.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>separated</u>	8. DATE OF BIRTH <u>May 10, 1922</u>	9. AGE (In years lost, birthday) <u>44</u>	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Mattox</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Wise</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Georgia L. Mattox Route 1 Comer Ga.</u>		
18. CAUSE OF DEATH <u>E 982 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Septicemia complicating multiple stab wounds.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>3/17/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>injuries</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>street</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>On street, La Fayette and Backley Street</u> <u>12-05</u>			
21D. TIME OF INJURY (APPROX.) <u>March 11, 67 12:35 A.M.</u>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>stabbed</u>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> DATE SIGNED <u>March, 18/67</u>							
23A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		23B. DATE <u>3-22-67</u>	23C. NAME of CEMETERY or CREMATORY <u>Fork Bethel</u>		23D. LOCATION (City, town, or county) (State) <u>Oglethorpe Co. Ga.</u>		
24A. DATE REC'D BY HEALTH DEPT. <u>MAR 27 1967</u>		24B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24C. FUNERAL DIRECTOR ADDRESS <u>Arlington S. Phillips 1727 N. Monroe Street</u>			

QUIET PAPER

1-25-67

1-25-67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 30-52-62 A2 E4		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2943	
M.E. CASE NO. 67 2943		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) KNIPP, RENE ASHWORTH		2. DATE AND HOUR OF DEATH 3/26/67 12⁰⁰ M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 13-07 3925 Beech Avenue			
5. SEX Female	6. RACE White	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 04-08-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Natick, Rhode Island	
13. FATHER'S NAME Noah Ashworth		14. MOTHER'S MAIDEN NAME HELEDA, Maria		12. CITIZEN OF WHAT COUNTRY? American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Husband Mr. Arthur R. Knipp	
18. 586X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism		CAUSE OF DEATH (A) DUE TO Pulmonary embolism (B) DUE TO Phlebotrombosis - site unknown (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 hr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary atelectasis in status post cholecystectomy					
19A. DATE OF OPERATION 3/25/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED expl. lsp.		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (†) (this hospital) attended the deceased from March 8 19 67 to March 26 19 67 , that (I) (we) last saw the deceased alive on March 26 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sun Young Choi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/26/67	
23C. PHYSICIAN'S NAME (Type) SUN YOUNG CHOI		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3/27/1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Fickert & Sons	
ADDRESS Baltimore, Md.					

Richardson - the same
Richardson

Richardson
Richardson
Richardson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2941	
BIRTH NO. 67 2941		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) METCALFE HERBERT C.		2. DATE AND HOUR OF DEATH 3-22-67 11:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY W.3.A C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5226 Kelway Road 21218	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-5-97
9. AGE (in years last birthday) 69		10. IF Under 1 Yr. Months Days	11. IF Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - ACCOUNTANT		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME DECEASED William Robert Metcalf		14. MOTHER'S MAIDEN NAME DECEASED Margaret Isabelle Sherwin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-3569	
17. INFORMANT NORTH CHARLES GENERAL HOSPITAL		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CA LUNG C METASTASIS		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-13-67 to 3-23-67 that (I) (we) last saw the deceased alive on 3-23-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Chanthara Buddhimondala M.D.		23B. DATE SIGNED 3-22-67	
23C. PHYSICIAN'S NAME (Type) ROBERT ROUBENOFF M.D.		23D. ADDRESS NORTH CHARLES GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/1967	
24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons		ADDRESS Baltimore, Md.	

1. The first part of the report

is a description of the

method used

for the

analysis of the

data obtained

from the experiments

conducted in the

laboratory of the

Department of

Physics

at the

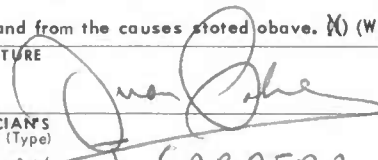
FUNERAL DIRECTOR: IMPORTANT

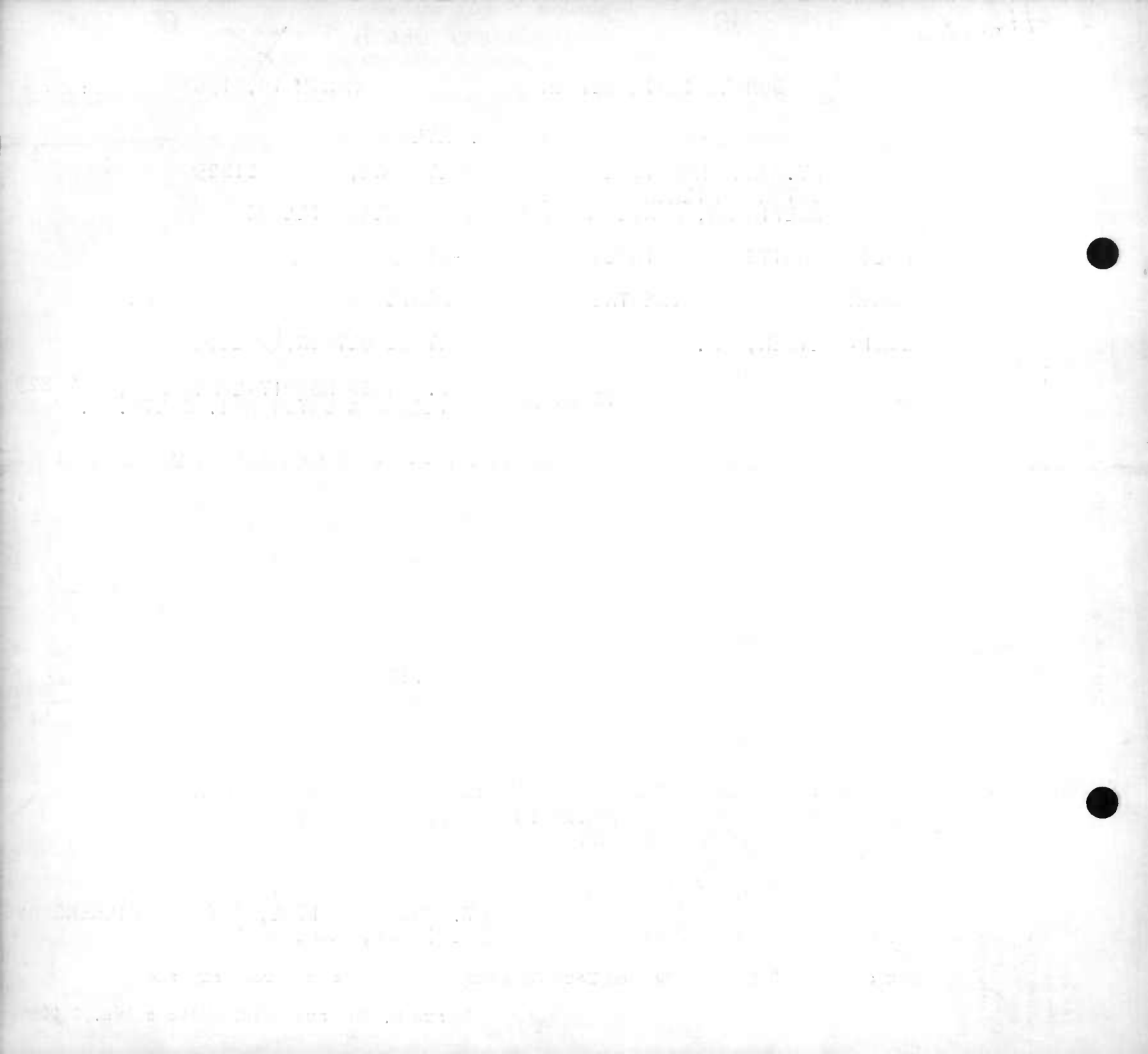
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2945		CERTIFICATE OF DEATH		Registered No. 67 2945	
1. NAME OF DECEASED (Type or Print) Ella V. Shackelford				2. DATE AND HOUR OF DEATH March 23, 1967 9 ⁵⁰ A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 564 West University Parkway Baltimore, Maryland 21210				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-07 D. STREET ADDRESS (If rural, give location) 564 W. University Parkway 10					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH April 7, 1896	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician - Retired			10B. KIND OF BUSINESS OR INDUSTRY Bendix Corporation			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Hezekiah L. Thomas				14. MOTHER'S MAIDEN NAME Mary Emma Pritchett					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Miss Helen Sherwood 4311 Marble Hall Rd.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X I Hypertensive Cardio-vascular Disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 14 months				19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from August 3 1946 to March 23 1967, that (I) (we) last saw the deceased alive on March 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE W. Griffin Hersberger				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED March 24, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Wm. F. Richmond Sons North Ave. Address					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2946	
BIRTH NO. 67 2946		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DONALD IRVIN OLIVER		MARCH 19, 1967 7:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE, MARYLAND 21229		A. STATE MARYLAND			
		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 21229			
		D. STREET ADDRESS (If rural, give location) 116 OAKLEE VILLAGE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11-11/33	9. AGE (In years last birthday) 33	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USHER		10B. KIND OF BUSINESS OR INDUSTRY THEATRE	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME EDWIN OLIVER, SR.			14. MOTHER'S MAIDEN NAME ETHEL OLIVER, (DULEY),		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 34 9366		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS, 21229 WILKENS & CATON AVE. BALTO. MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 260X4340.3 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DIABETES MELLITUS - (DIABETIC) DUE TO (B) COMA - PROBABLY MENINGITIS DUE TO (C) ACUTE RENAL FAILURE -			
INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MARCH 18 19 67 to MARCH 19 19 67 , that (X) (we) last saw the deceased alive on MARCH 19 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (XX) (did not) view the body after death.					
23A. SIGNATURE  JUAN J. CABRERA				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JUAN J. CABRERA		23D. ADDRESS ST. AGNES HOSPITAL, CATON & WILKENS AVE BALTIMORE, MARYLAND 21229			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/23/67	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2947		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2947	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) George Edward Robinson			March 20, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital Wilkins & Caton Aves.			A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1114 Pine Heights Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH 7/18/95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Robinson			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 21229 Marie M. Robinson 1114 Pine Heights Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 420.1 DUE TO A. ACUTE MASSIVE MYOCARDIAL INFARCTION B. A.C.U. C. C.A. - ALCOHOLIC			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/1 1952 to 3/20 1967, that (I) (we) last saw the deceased alive on 3/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. John Shaw				23B. DATE SIGNED 3/20/67	
23C. PHYSICIAN'S NAME (Type) Dr. John Shaw				23D. ADDRESS Edmondson Ave. & Overbrook Road, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore County, Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229		25D. ADDRESS		25E. ADDRESS	



M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LLOYD HUGHES

2. DATE AND HOUR PRONOUNCED DEAD

3-22-67 1:50 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

347 S. NEWKIRK STREET - Amb. Crew #2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

347 S. Newkirk Street - 21205

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1-14-1899

9. AGE (In years
lost birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Brick Mason

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wilkes Barre, Penna.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Robert E. Hughes

14. MOTHER'S MAIDEN NAME

Elizabeth Lloyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

211-10-1025

17. INFORMANT

ADDRESS

Mrs. Merle Klavonski, 114 Academy St.

Plymouth
Pa.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic
XXXXX
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

3-22-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-25-1967

23C. NAME of CEMETERY or CREMATORY

Mt. Greenwood Cemetery

23D. LOCATION

(City, town, or county)

(State)

Trucksville, Pannsylvania

24A. DATE REC'D BY HEALTH DEPT.

MAR 28 1967

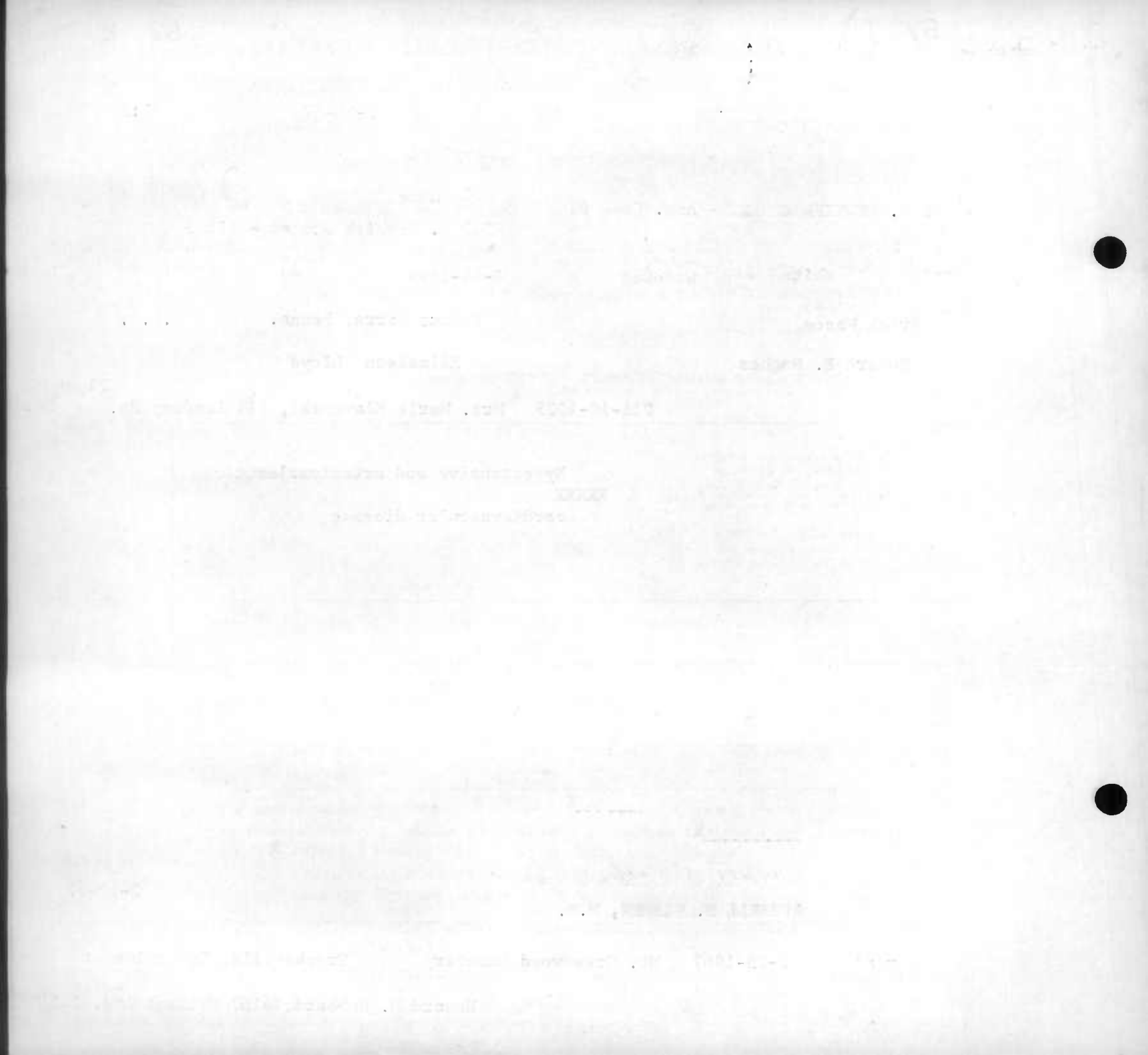
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

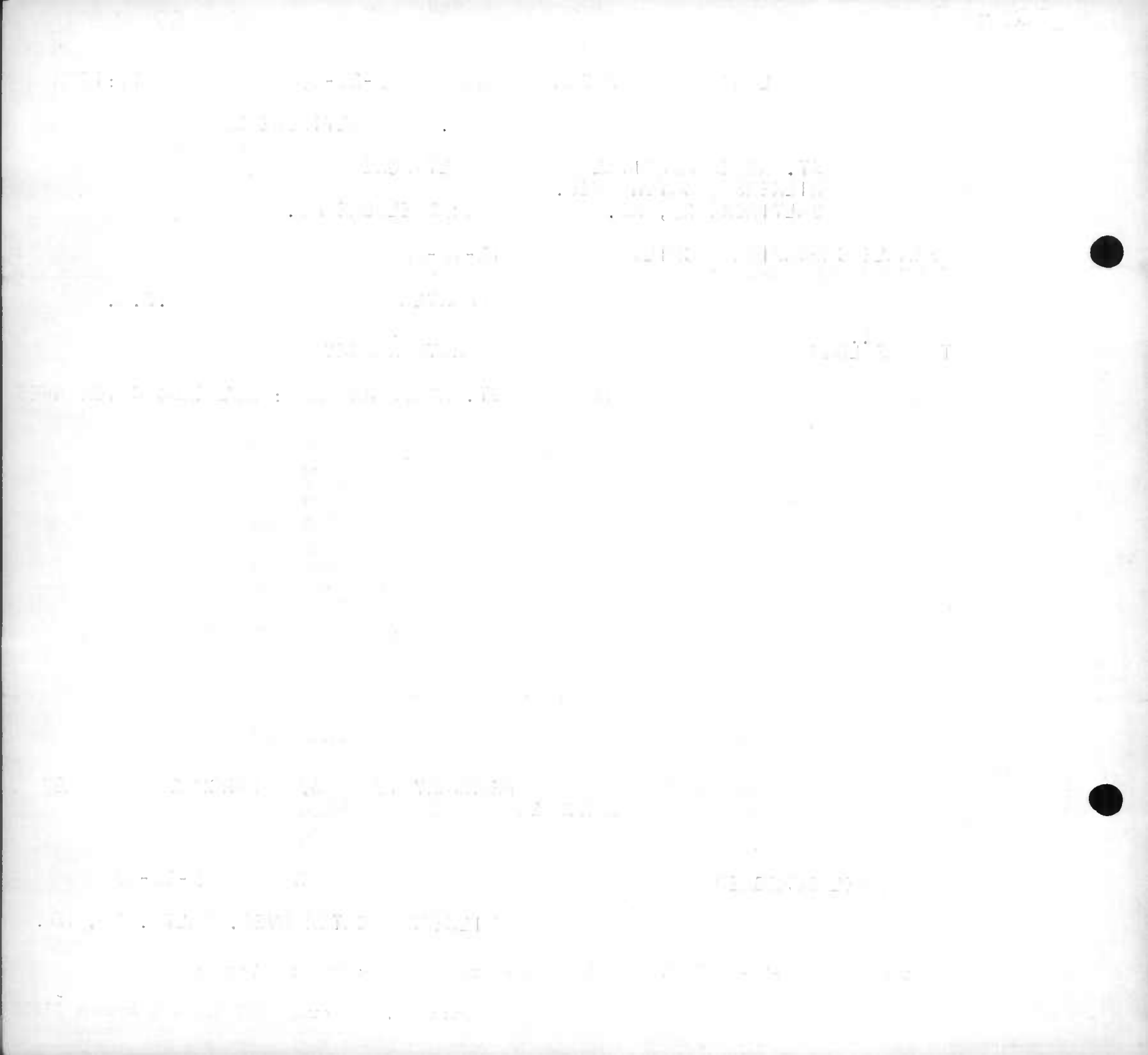
BIRTH NO. 67 2949		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2949	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mrs Lillian Orion			2. DATE AND HOUR OF DEATH 3/20/1967/30 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital 34 2025 West Fayette St.			A. STATE B. COUNTY 402 N. Monroe St		
5. SEX female			6. RACE white		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH 12/2/86		
9. AGE (In years lost birthday) 80			10. CITIZEN OF WHAT COUNTRY? U.S.A		
11. BIRTHPLACE (State or foreign country) Baltimore Md			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Rudolf Timmerman			14. MOTHER'S MAIDEN NAME Marie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-09-9270		
17. INFORMANT Henry F. Prior			ADDRESS 402 N. Monroe St. 21223		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Acute myocardial infarct 8 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Ocul. (L) descending coronary		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Hypertensive arteriosclerosis		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 3/17/67 to 3/20/67 that (I) (we) last saw the deceased alive on 3/20/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 3/20/67		
23C. PHYSICIAN'S NAME (Type) A. A. MENDOZA			23D. ADDRESS M.D. BON SECOURS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 28 1967		24F. NAME OF REGISTRAR Robert E. Fairbank	
24G. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2950	
BIRTH NO. 67 2950		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) LONG SUSAN ANN		3-20-67 11:15PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE 29, MD.		A. STATE MD. B. COUNTY BALTIMORE 29	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 4432 ELDONE RD.	
5. SEX FEMALE	6. RACE CAUCASION	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 12-15-59
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 7
		11. BIRTHPLACE (State or foreign country) MARYLAND	(If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.)
13. FATHER'S NAME THOMAS L. LONG		14. MOTHER'S MAIDEN NAME RUTH RUMNEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
		17. INFORMANT ADDRESS ST. AGNES RECORDS: WILKENS & CATON AVES	
18. 15 6/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the liver		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 15 6/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 10 19 67 to MARCH 20 19 67 , that (I) (we) last saw the deceased alive on MARCH 20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE AZAZEL BORRAMEO		23B. DATE SIGNED 3-20-67	
23C. PHYSICIAN'S NAME (Type) Borrimeo		23D. ADDRESS M.D. WILKENS & CATON AVES. BALTO. 29, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-23-1967	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR Robert S. Hubbard	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2951				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2951	
1. NAME OF DECEASED (Type or Print) Edna May Wirtz				2. DATE AND HOUR OF DEATH 3/21/67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2809 Sunset Drive Baltimore, Maryland 21223				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2809 Sunset Drive, Baltimore City 21223 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2809 Sunset Drive			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 10/22/96		9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME (Full name) John Eisenhower			14. MOTHER'S MAIDEN NAME Sophia		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		
16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Carl M. Wirtz 2909 Stafford St. 21223				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ac. Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 4-20-1			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic c.v. disease, Hypertension, chronic Arthritis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 1966 to March 17 1967 , that (I) (we) last saw the deceased alive on March 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albina Klimas M.D.				23B. DATE SIGNED 3-22-67		23C. PHYSICIAN'S NAME (Type) Albina Klimas M.D.	
23D. ADDRESS 2030 Wilkens Ave.							
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 3/24/67		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 2952		Registered No. 67 2952	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) WALTER A. STAYLOR		2. DATE AND HOUR OF DEATH 3-21-67 9³⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE MD.			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 116 S. GILMORE ST.			
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 11-12-05	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WALTER A. STAYLOR		14. MOTHER'S MAIDEN NAME SARAH BELLE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-18-5908		17. INFORMANT Mrs. Eva J. Sperlein, 212 S. Stricker St.	
18. 384X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 Week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3-10-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLELITHIASIS		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/7 19 67 to 3/21 19 67 , that (I) (we) last saw the deceased alive on 3/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Edward A. Person		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/21/67	
23C. PHYSICIAN'S NAME (Type) EDWARD A. PERSON		23D. ADDRESS MARYLAND GENERAL HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-1967		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967			
25B. NAME OF REGISTRAR Robert E. Falsbarna		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 2953</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67 2953</u> CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>AGNES MARY LE MASTER</u>			2. DATE AND HOUR OF DEATH <u>MARCH 23, 1967 6:00 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>LeMaster</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 FRANKLIN SQUARE HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>21-01</u> D. STREET ADDRESS (If rural, give location) <u>809 W. BARRE ST. 30</u>		
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>1/26/1900</u>	9. AGE (In years lost birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>C & P. Telephone</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>HENRY AUGUST KUMMER</u>			14. MOTHER'S MAIDEN NAME <u>IDA ECHEMAN DECEASED</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>DECEASED</u>			16. SOCIAL SECURITY NO. <u>212-03-6425</u>		17. INFORMANT <u>MIRIAM MILBURN (DAUGHTER)</u>
			ADDRESS <u>811 W. BARRE BALTIMORE</u>		
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION</u> (A) DUE TO (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/15/1967</u> to <u>3/23/1967</u>, that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas G. Alvero</u>				23B. DATE SIGNED <u>3/23/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>TOMAS A. ALVERO</u>				23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-27-1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 28 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>	



J-520

67 2954

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2954

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUNICE

JUNG

2. DATE AND HOUR PRONOUNCED DEAD

March 23, 1967

9:15 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1040 Middleboro Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JAN 6 1942

9. AGE (In years
lost birthday)

26 25

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PA.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

THOMAS CROZIER

14. MOTHER'S MAIDEN NAME

EUNICE KLABURNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

220-38-6261

17. INFORMANT

VERNON JUNG

ADDRESS

ABOVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Intraperitoneal Hemorrhage.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Rupture of Liver.
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3 21-22 '67

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Possible fall.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/23/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3/27/67

23C. NAME of CEMETERY or CREMATORY

GARDENS OF FAITH

23D. LOCATION

(City, town, or county)

BALTO. MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 28 1967

24B. NAME OF REGISTRAR

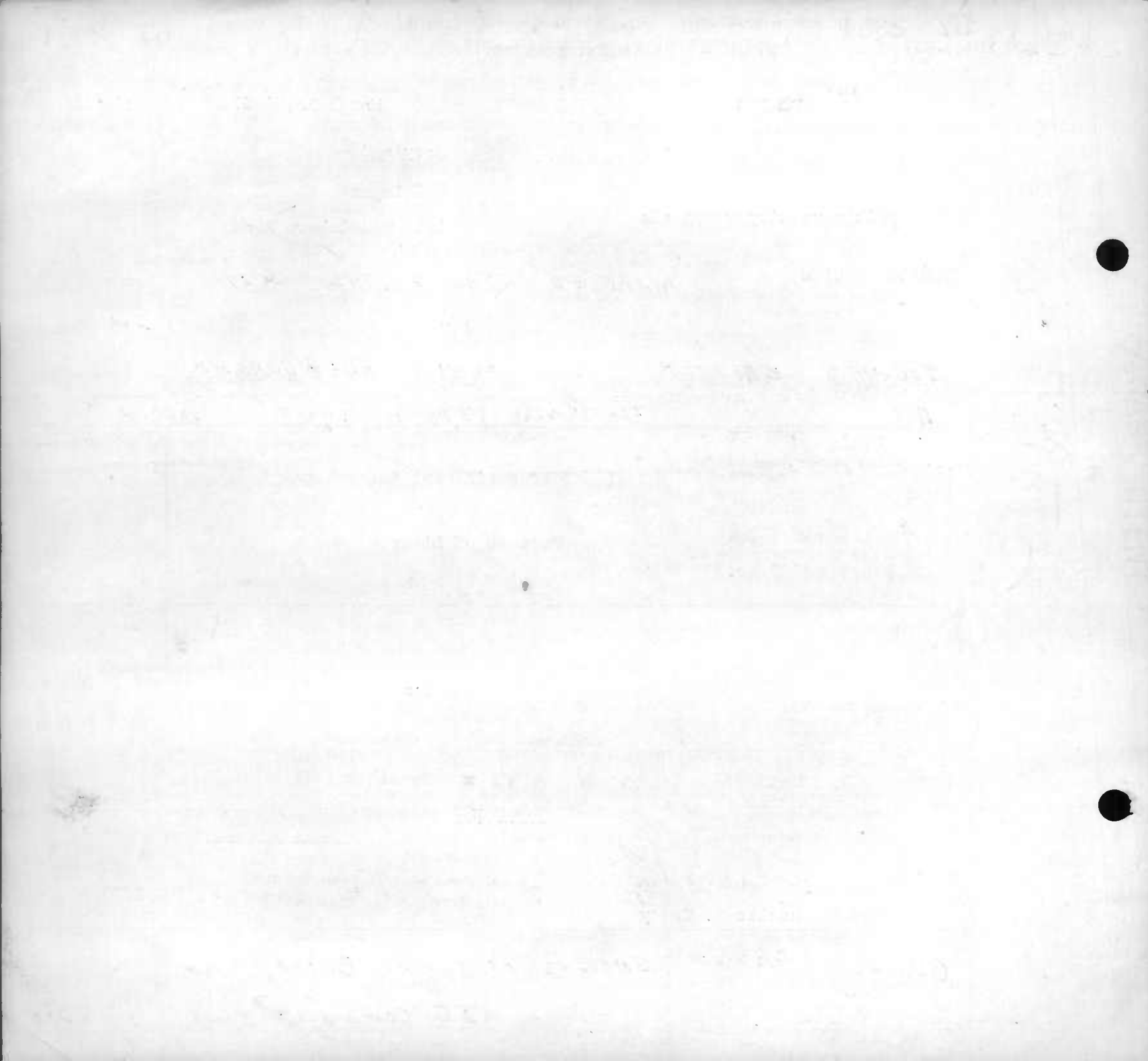
R. E. Faldut

24C. FUNERAL DIRECTOR

J.G. CONNOLLY SONS

ADDRESS

300 MACE



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2955		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2955	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JENKINS, MARIE		2. DATE AND HOUR OF DEATH 3-25-67 10:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE COUNTY COLGATE D. STREET ADDRESS (If rural, give location) 7600 POPLAR AVENUE 21224 53-00			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-18-07	9. AGE (In years last birthday) 59	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WEIGAND RIPLE			
14. MOTHER'S MAIDEN NAME AMANDA BOHLE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH: RECORDS 4940 EASTERN AVENUE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RECURRENT CAUSE OF DEATH		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 Year	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-25-1967 to 3-25-1967, that (I) (we) last saw the deceased alive on 3-25-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eusebio Kho		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-25-67	
23C. PHYSICIAN'S NAME (Type) DR. EUSEBIO KHO		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/29/67		24C. NAME OF CEMETERY or CREMATORY SCHWARTZ CEM	
24D. LOCATION BALTO. MD.		24E. DATE REC'D BY HEALTH DEPT. MAR 28 1967			
24F. NAME OF REGISTRAR Robert E. Farber		24G. FUNERAL DIRECTOR J.G. CONNELLY SONS		24H. ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2956		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2956	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PAUL MABRY		2. DATE AND HOUR OF DEATH 3-23-67 1:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Holman Hospital of Maryland		A. STATE Maryland B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-07			
		D. STREET ADDRESS (If rural, give location) 347 N. DENISON ST.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-9-86	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HENRIED CO. N.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME TOLA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS GRACE FLIPPIN 347 N. DENISON ST.	
18. 446X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) UREMIA DUE TO (B) NEPHROSCLEROSIS (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		BENIGN PROSTATIC HYPERTROPHY			
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-22-67 to 3-23-67, that (I) (we) last saw the deceased alive on 3-23-67 and that in (my) (our) opinion death occurred on the date and hour and place the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas C. Vidhyaphum M.D.		23B. DATE SIGNED 3-23-67			
23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDHYAPHUM M.D.		23D. ADDRESS Holman Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 3/23/67		24C. NAME OF CEMETERY or CREMATORY Gaston	
24D. LOCATION (City, town, or county) (State) Gaston N.C.					
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Paul E. Farber		25C. FUNERAL DIRECTOR William H. Weldon N. ADDRESS William H. Weldon 638 Gaston St	



1
P-630

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2957

M.E. CASE NO.				2. DATE AND HOUR PRONOUNCED DEAD			
1. NAME OF DECEASED (Type or Print)				3-26-67 2:10 P. M.			
McKINLEY PRATT							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland			
541 N. MOUNT STREET - Amb. Crew #4				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location)				21223			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		Colored				Jan 11-1910	
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
57		Handyman		Baltimore MD		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				25-05-8645A		MADONIA PRATT 541 N MOUNT ST	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Laennec's cirrhosis			
DUE TO							
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Chronic bronchitis and emphysema			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED			
RUSSELL S. FISHER, M.D.				3-27-67			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		3/30/67		Mt Auburn		Baltimore	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
MAR 28 1967		Robert E. Fisher		Mamie P. Patten		638 N. G. Mon St	

1 9 6 7 0 0 0 2 9 6 6

Jan 11-12 27

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN E.

SIPES

2. DATE AND HOUR PRONOUNCED DEAD

March 24, 1967

6:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3442 6th St.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3442 6th St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

April 26, 1884

9. AGE (In years
lost birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired-airbrake mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Leonard A. Sipes

14. MOTHER'S MAIDEN NAME

Louise Pfaum

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-05-9989

17. INFORMANT

ADDRESS

Mrs. Mamie Sipes - same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic heart disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

March 28, 1967

23C. NAME of CEMETERY or CREMATORY

Glen Haven Memorial Pk.

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy., A.A. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

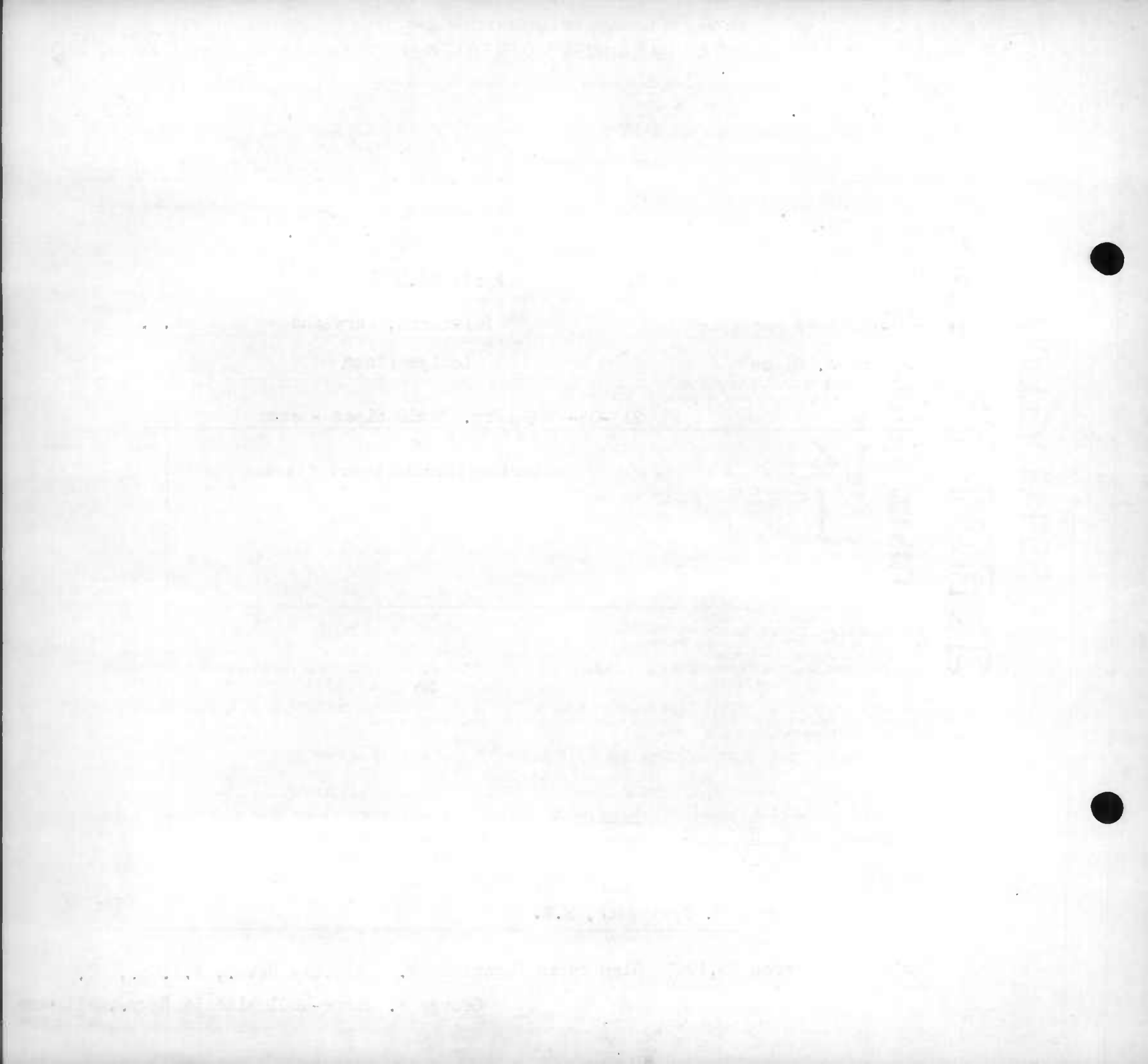
MAR 28 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

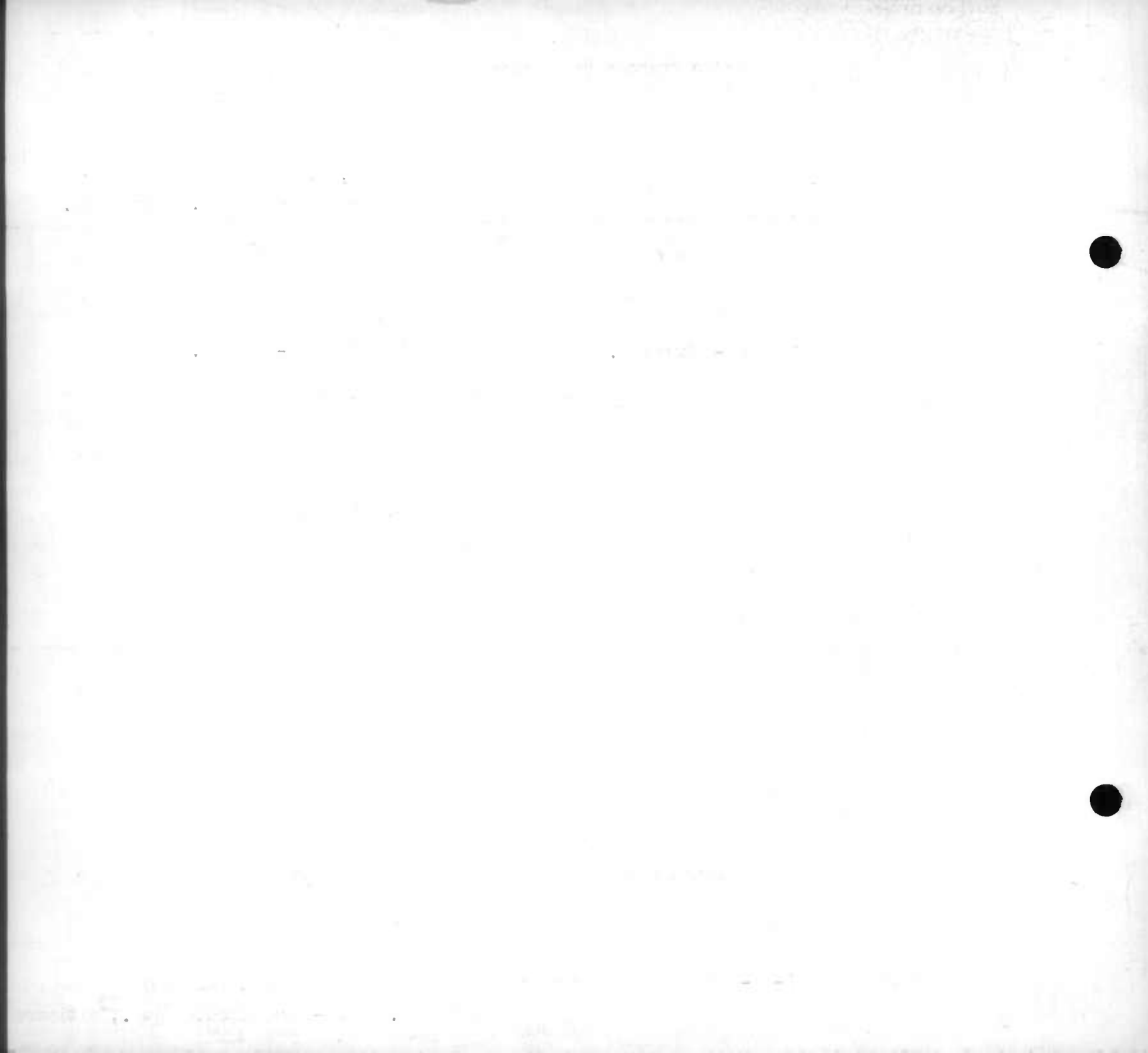
George J. Gonc - 4001 Ritchie Hwy., Baltimore



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2959		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2959	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Bertha Frances Hazlegrove		2. DATE AND HOUR OF DEATH 3-24-67 12-20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY U.S.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 21225 D. STREET ADDRESS (If rural, give location) 14000 BROADWAY 204 W. Arundel Rd.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-15-90	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND, U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DECEASED - Thomas H. Beale			14. MOTHER'S MAIDEN NAME DECEASED - Mary F. Long		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-30-7844		17. INFORMANT ADDRESS NORTH CHARLES GENERAL HOSPITAL	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE DUE TO (B) ACUTE MYOCARDIAL INFARCTION DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 13 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-11 19 67 to 3-24 19 67 , that (I) (was) last saw the deceased alive on 3/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chanthana Suddhimonondak M.D.				23B. DATE SIGNED 3-24-67	
23C. PHYSICIAN'S NAME (Type) DANIEL WILFSON M.D.				23D. ADDRESS 5721 PARK HEIGHTS AVE. 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-28-1967		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy., Baltimore			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2960		BALTIMORE CITY DEPARTMENT		Registered No. 67 2960	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Anna Liesa Thomsen		March 26, 1967 12:10 p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE Maryland 21212			
(If not in hospital or institution, give street address or location) 524 Sheridan Avenue Baltimore, Md. 21212		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-10			
		D. STREET ADDRESS (If rural, give location) 524 Sheridan Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec. 16, 1899	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bernhard Alt		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 214-05-3836B		17. INFORMANT ADDRESS Wm. H. Thomsen (Husband) Same	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Jan 25 1967 to Mar 26 1967, that (I) (we) lost saw the deceased alive on Mar 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Kanner Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/27/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 6011 York Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) cremation		24B. DATE Mar 29/1967		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967			
25B. NAME OF REGISTRAR R. E. F. Adams		25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 Yord Rd. Seitz Funeral Home Balto. Md. 21212			

1 HEALTH X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 2961		CERTIFICATE OF DEATH		67 2961	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Rosario Zito</i>		2. DATE AND HOUR OF DEATH <i>3-21-67 5:20 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9.9 Co</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie 52-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>1011 Stewart Lane</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>10-25-1906</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Store Proprietor</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Conn.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Antonio Zito</i>		14. MOTHER'S MAIDEN NAME <i>Michelli</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-0035</i>		17. INFORMANT <i>Chart</i>	
18. <i>433.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cardiac Arrest</i> DUE TO (B) <i>Complete atrio-ventricular block days</i> DUE TO (C) <i>Atherosclerotic Cardio-vascular disease</i> years		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-18-1967</i> to <i>3-21-1967</i> , that (I) (we) last saw the deceased alive on <i>3-20-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Octavio A. Ruiz</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>3/21/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Octavio H. Ruiz</i>		23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/24/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Memorial</i>	
24D. LOCATION (City, town, or county) (State) <i>Glen Burnie Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 28 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Singleton Funeral Home</i>	
				ADDRESS <i>Glen Burnie</i>	

San Jose, California

San Jose, California

10-23-1906

10-23-1906

10

State Hospital

San Jose

Antonio L. to

Mr. Chelle

Chart

San Jose

10

San Jose, California
State Hospital
Antonio L. to
Mr. Chelle
Chart
San Jose

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Jennie Temple		3/21/67		10:45 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Bolton Hill Nursing Center FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
1400 John Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
90		D. STREET ADDRESS (If rural, give location)		1400 John Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	White	Widowed	11/9/1879	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Greensburg, Pa.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jacob Zimmerman		Anna Blank		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		113-12-2790		Mabel Temple - Linthicum, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Pneumonia		Pneumonia		7 wks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (If in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from October 1967 to 3/21 1967. that (I) (we) last saw the deceased alive on 3/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Christian S. Mass, M.D.		3/21/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CHRISTIAN S. MASS, M.D.		687 Baltimore National Pike. Ellicott City, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		3/25/67		St. Clair Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Greensburg, Pa.					
25A. DATE RECEIVED FOR DEATH CERT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 28 1967		Robert E. Farkas		Singleton Funeral Home/Glen Burnie, Md.	



1
S-160

BIRTH NO. 67 2963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2963

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ALBION SAVER 2. DATE AND HOUR PRONOUNCED DEAD 3-26-67 10:10 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 604 JASPER STREET - Amb. Crew #1 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01

D. STREET ADDRESS (If rural, give location) 604 Jasper Street 21201

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE 8. DATE OF BIRTH 3/23/1924 9. AGE (In years lost birthday) 44 If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JACOB SAUER 14. MOTHER'S MAIDEN NAME CHRISTINE BERKOPEC

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS MRS. CHRISTINE B. SAUER, PITT., PA.

18. 420.0 CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO

19A. DATE OF OPERATION 2. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL-TRANSIT 338-67 23B. DATE 23C. NAME OF CEMETERY or CREMATORY ST. MARY'S 23D. LOCATION (City, town, or county) (State) PITTSBURGH, PENN.

24A. DATE REC'D BY HEALTH DEPT. MAR 28 1967 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS MITCHELL-WIEDEFFELD HOME 6500 YORK RD. BALTO. MD. 21212

VS 151-REV. 1/1/65

SINGLE

3/23/1924

JACOB SAVER

Yes - W. W. II

CHRISTINE BERKOFER

Mrs. CHRISTINE SAVER

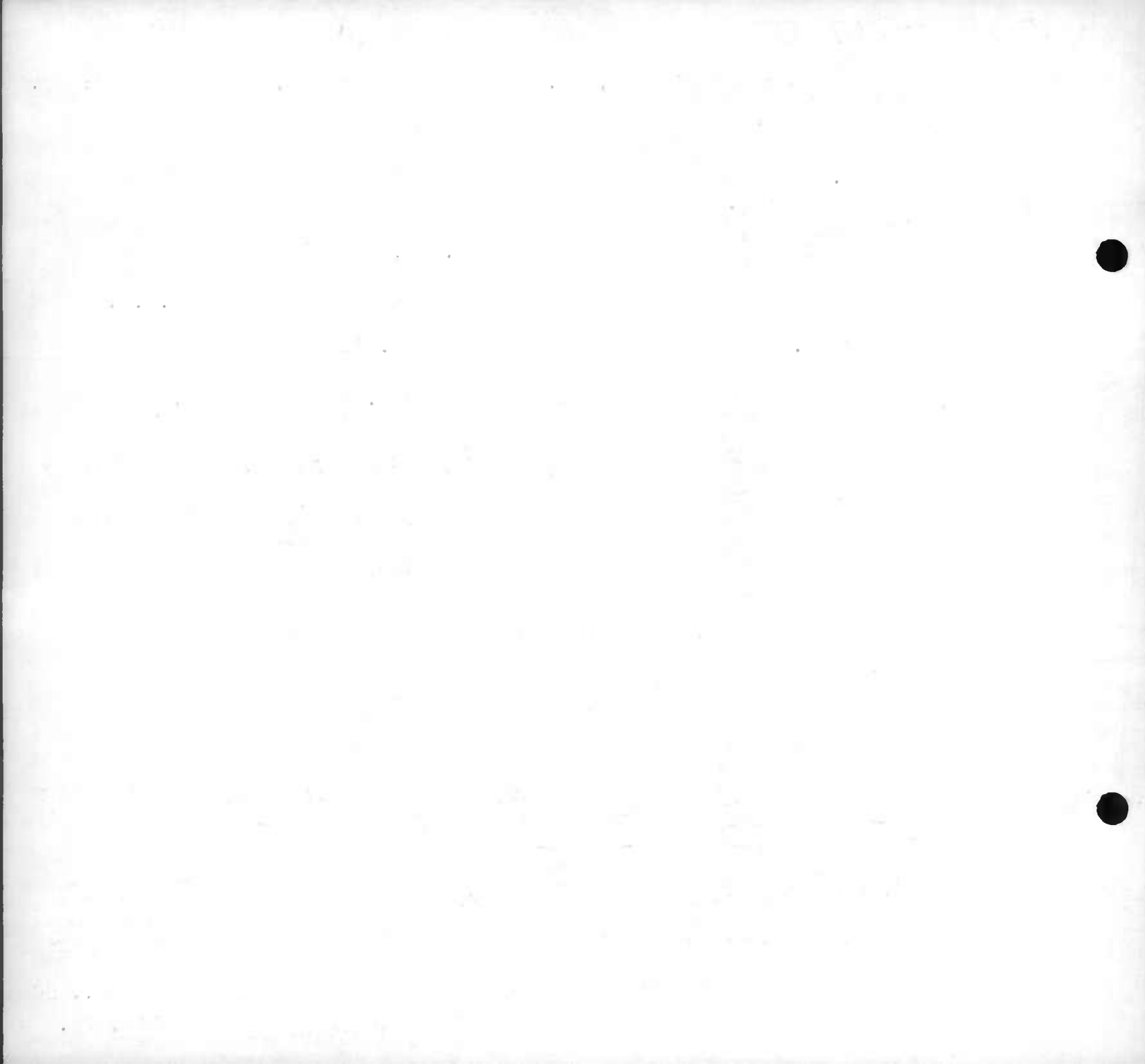
Burn - Throat - 3/1/23 St. Mary's

St. Mary's

St. Mary's

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 2964	
CERTIFICATE OF DEATH											
BIRTH NO. 67 2964											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)		James Edward Huff, Sr.								2. DATE AND HOUR OF DEATH March 23, 1967 2:25pm.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Harford Co.									
FULL NAME OF HOSPITAL OR INSTITUTION Edith A. Anderson Nursing Home		(If not in hospital or institution, give street address or location) 3604 Mohawk Ave.									
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH Dec. 27, 1881		9. AGE (In years last birthday) 85		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Augustus A. Huff				14. MOTHER'S MAIDEN NAME Susan J. Thomas							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-4437		17. INFORMANT ADDRESS Delmer T. Huff Street, Maryland							
18. 5-92XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) (1) - Broncho-pneumonia - 7 days DUE TO (B) (2) Arterio Sclerotic Heart Disease - 5 yrs DUE TO (C) Chronic Hepatitis - 1 yr.								INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Generalized Arterio Sclerosis									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1965 to March - 23, 1967 , that (I) (we) last saw the deceased alive on March - 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE Earl L. Chambers		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/24/67							
23C. PHYSICIAN'S NAME (Type) EARL L. CHAMBERS M.D.		23D. ADDRESS 4108 LIBERTY HEIGHTS AVE. BALTIMORE MARYLAND									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/67		24C. NAME OF CEMETERY OR CREMATORY Ascension Church Cemetery				24D. LOCATION (City, town, or county) (State) Street, Harford Co., Md			
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR John H. Harkins		25C. FUNERAL DIRECTOR John H. Harkins				ADDRESS Delta, Pa.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED

BIRTH NO. 67 2965		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2965	
M.E. CASE NO. 1			1. NAME OF DECEASED (Type or Print) Bertha E. Kramer		
2. DATE AND HOUR OF DEATH March 21, 1967 3P M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND 002124 E. Federal Street		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			5. CITY OR TOWN (If outside city limits, write RURAL and give township) 8-02		
6. STREET ADDRESS (If rural, give location) 2124 E. Federal Street			7. DATE OF BIRTH Mar. 16, 1885		
8. SEX Female			9. RACE White		
10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed			11. AGE (In years lost 1 day) 82		
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			13. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
14. KIND OF BUSINESS OR INDUSTRY			15. CITIZEN OF WHAT COUNTRY? U.S.A.		
16. FATHER'S NAME August Schwichtenberg			17. MOTHER'S MAIDEN NAME Augusta Bein Krieger		
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			19. SOCIAL SECURITY NO. -		
20. INFORMANT Bertha Valdona H. Clarke-2124 E. Federal St.			21. ADDRESS		
22. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			25. MEDICAL CERTIFICATION		
26. DATE OF OPERATION 0			27. CONDITION FOR WHICH OPERATION WAS PERFORMED		
28. AUTOPSY? (Yes or No) No			29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			33. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
34. INJURY OCCURRED			35. HOW DID INJURY OCCUR?		
36. I certify that (I) (this hospital) attended the deceased from May 17 19 62 to March 21 19 67 , that (I) (we) last saw the deceased alive on March 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			37. SIGNATURE Clarence W. LeDoux M.D.		
38. PHYSICIAN'S NAME (Type) Clarence W. LeDoux M.D.			39. DATE SIGNED 3/23/67		
40. ADDRESS 3023 Eastern Ave. Baltimore Md.			41. BURIAL CREMATION, REMOVAL (Specify) Burial		
42. DATE 3-25-67			43. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		
44. LOCATION (City, town, or county) (State) Baltimore, Maryland			45. DATE REC'D BY HEALTH DEPT. MAR 28 1967		
46. NAME OF REGISTRAR Robert E. Farkas			47. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		

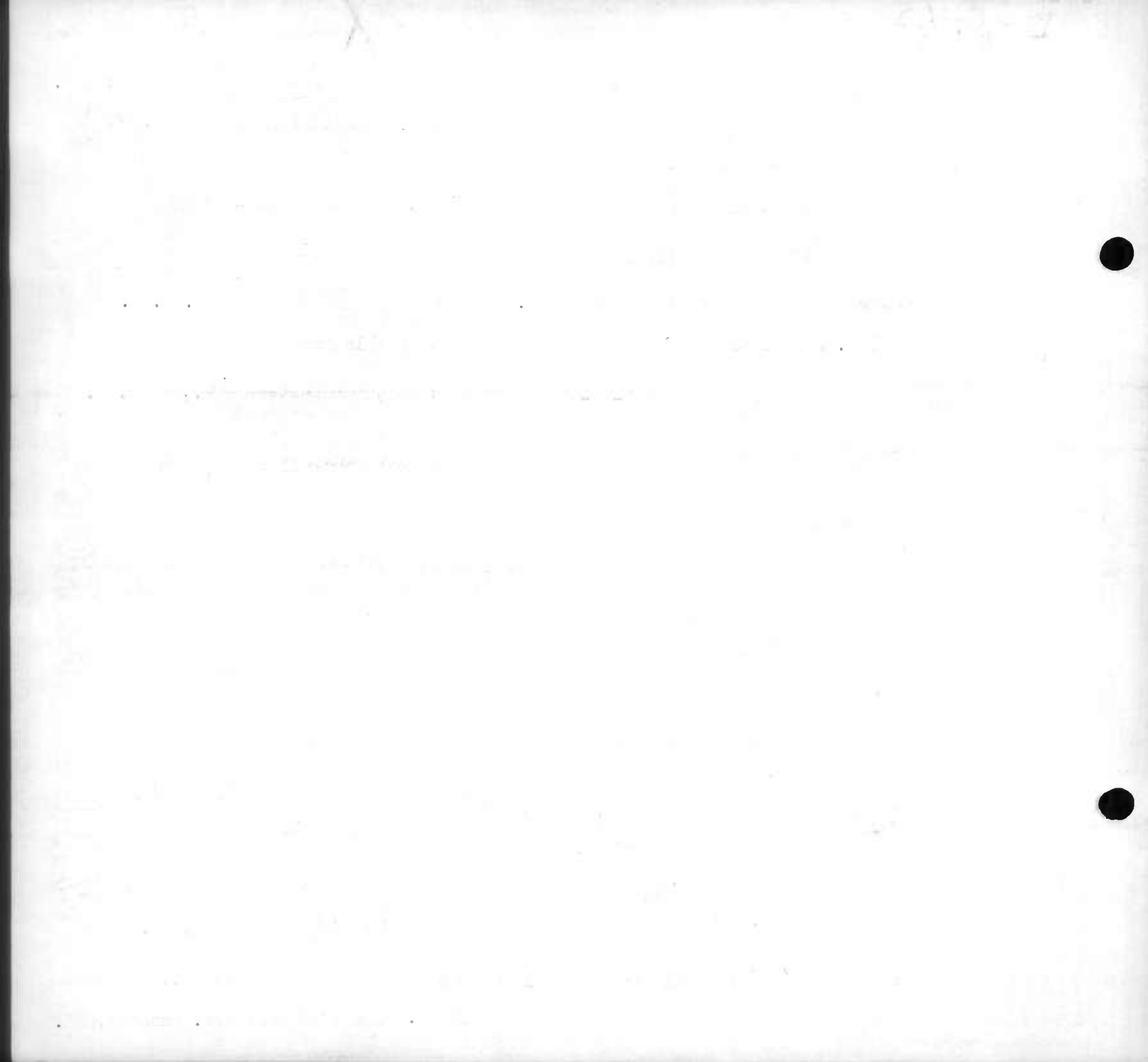
Deceased's Baptismal Record
10-7-69 M. A.

CLARENCE YWENZ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2966		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2966	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RAYMOND R DANIELSON		2. DATE AND HOUR OF DEATH 3/25/67 8:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Edgemere	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location) 2515 S. SNYDER AVENUE - 21219		5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 4/3/15		9. AGE (In years lost birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Daniel E. Danielson	
14. MOTHER'S MAIDEN NAME Esther Ahlstrom		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army WWII		16. SOCIAL SECURITY NO. 503-05-6559	
17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224		18. CAUSE OF DEATH inhacranial bleed		INTERVAL BETWEEN ONSET AND DEATH 4 days	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hypertension		2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from 3/21/67 19 to 3/25/67 19 that (I) we last saw the deceased alive on 3/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce M. Dow				23B. DATE SIGNED 3/25/67	
23C. PHYSICIAN'S NAME (Type) BRUCE M. DOW				23D. ADDRESS BCH, 4940 Eastern Avenue Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/29/67		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens	
24D. LOCATION Bel Air, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md.		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2967		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 2967	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAKI, MARI K.		2. DATE AND HOUR OF DEATH 3/25/67 7:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 7010 Fair Ave.			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 9/7/81	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) FINLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-32-2570		17. INFORMANT ADDRESS admission Record	
18. 586X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pulmonary edema DUE TO ascua (B) Peritonitis DUE TO (C) obstructive jaundice		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3/19/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice		20. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in home, farm, factory, street, office bldg., etc.) ACTN E		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/22/67 19 67 to 3/25 19 67 , that (I) (we) last saw the deceased alive on 3/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Fred R. Eilber		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/25/67	
23C. PHYSICIAN'S NAME (Type) FRED R. EILBER		23D. ADDRESS MARYLAND General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/67		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2968		CERTIFICATE OF DEATH		Registered No. 67 2968	
1. NAME OF DECEASED (Type or Print) Bertie A. Prell						2. DATE AND HOUR OF DEATH March 26, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 613 Allendale Street						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16-08 D. STREET ADDRESS (If rural, give location) 613 Allendale Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Jan. 20, 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, C&P Tel. Co.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James W. E. Selway				14. MOTHER'S MAIDEN NAME Mary A. Fisher					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-05-7235		17. INFORMANT Mrs. Charles Donaldson, 304 Sixth Street, Laurel, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION - 2 days				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO DIABETES MELLITUS - 3 yrs				(B) DUE TO ARTERIO SCLEROTIC C.V. 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 2-3 1966 to 3/26/67 19 that (I) (we) last saw the deceased alive on 3/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Norman R. Kleiman M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/27/67			
23C. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN M.D.				23D. ADDRESS 3803 EDMONDSON AVE. - BALTIMORE, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 29, 67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR G. Truman Schwab, 3512 Frederick Ave. Balto, Md.					



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67 2969

BALTIMORE CITY HEALTH DEPARTMENT

67 2969

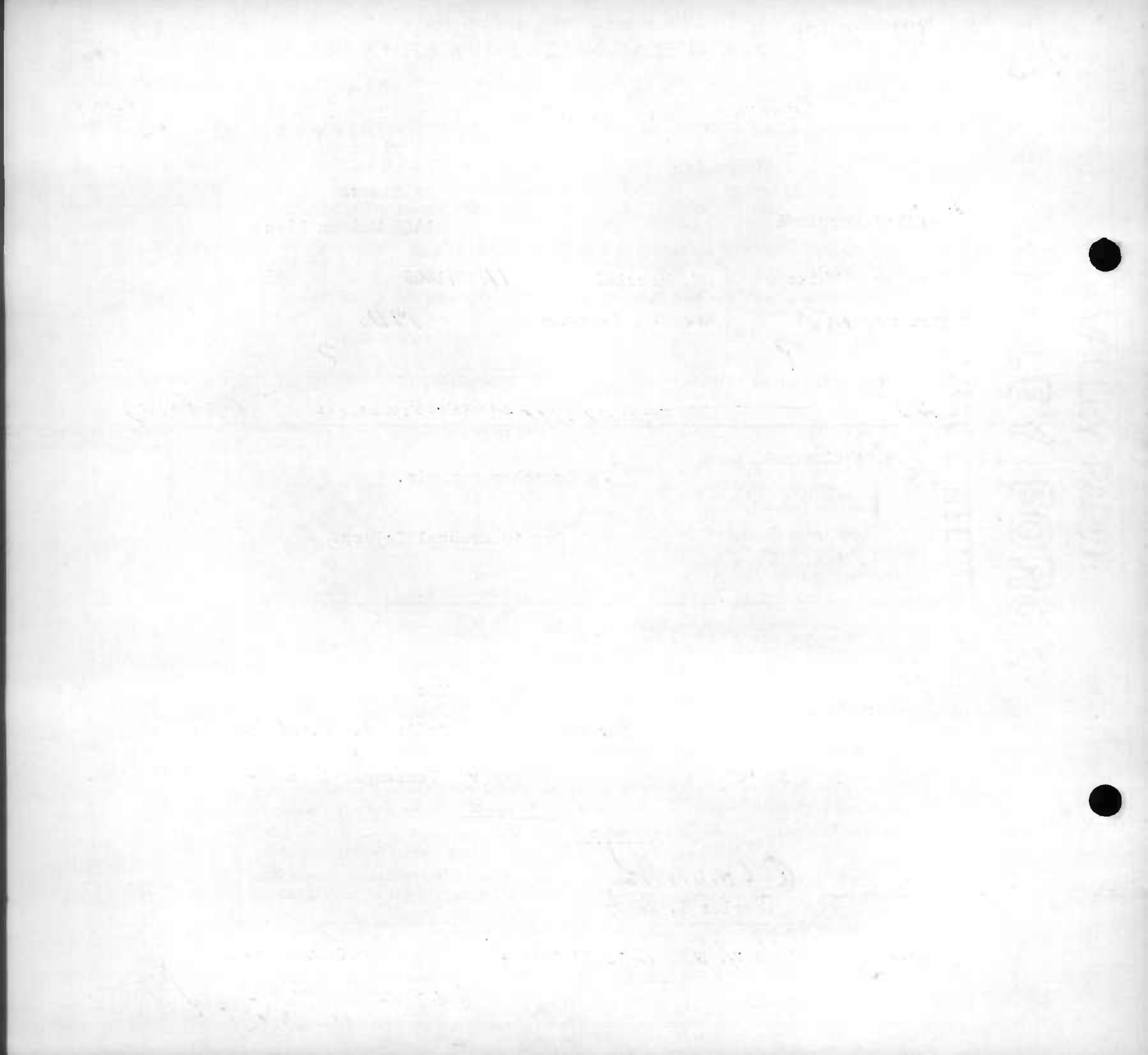
BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
IDONIA SULLIVAN		March 24, 1967 4:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Sinai Hospital		Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		1408 Weldon Place	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	White	Married	14/20/1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday)
SECRETARY		MASONIC TEMPLE	61
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MD			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
?		?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		21209-6598	LAWRENCE SULLIVAN (SAME)
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
(A) Bronchopneumonia. DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
(B) Craniocerebral Injury. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	Street	Falls Rd., S. of Harvest Road	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	Passenger in auto-auto collision.	
3	5 '67 A		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		3/24/67	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
CREMATION	3/27/67	GREENMOUNT	BALTO. MD.
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS	
MAR 28 1967	Robert E. Farley, M.D.	Paul E. Chavette, Jr. 3117 Chestnut Ave.	

VS 151-REV. 1/1/65

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 2970					REGISTERED NO. 67 2970					
CERTIFICATE OF DEATH										
1. NAME OF DECEASED (Type or Print) Henrietta MYERS, ETTA, CATHERINE					2. DATE AND HOUR OF DEATH 3-26-67 6:55A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON & WILKENS AVE. BALTIMORE, MD. 21229					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 21207 D. STREET ADDRESS (If rural, give location) 1212 NEWFIELD RD.					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED		8. DATE OF BIRTH 09-07-95		9. AGE (In years last birthday) 71		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) NEW YORK		
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME ALBERT KLEIN					
14. MOTHER'S MAIDEN NAME CATHERINE LICHTENHELDT					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					
16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVE. BALTIMORE, MD.					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) Metastatic disease to lungs and liver. INTERVAL BETWEEN ONSET AND DEATH Carcinoma of the breast. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 3-21			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3-21 19 67 to 3-26 19 67 , that (I) (we) last saw the deceased alive on 3-26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Pablo Dibos					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 3/26/67		
23C. PHYSICIAN'S NAME (Type) PABLO DIBOS					23D. ADDRESS M.D. ST. AGNES HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 3/30/67			24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATL. CEMETERY			24D. LOCATION (City, town, or county) (State) Balto. Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967			25B. NAME OF REGISTRAR Paul E. Farber			25C. FUNERAL DIRECTOR ADDRESS WEBER FUNERAL HOME 5311 EDMONDSON AVE				

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67 2971

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2971

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILFORD

EDWARDS

2. DATE AND HOUR PRONOUNCED DEAD

March 24, 1967

7:56

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2124 Harman Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2/2/14

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William I. Edwards

14. MOTHER'S MAIDEN NAME

Ella V. Lusby

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

28-12-9419

17. INFORMANT

ADDRESS

Mary O. Edwards 2124 Harman Ave

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

Hypertensive and arteriosclerotic
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/28/67

23C. NAME of CEMETERY or CREMATORY

Bieder Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 28 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Ambrose, Inc. 1328 Sulphur Sp. Rd.

ADDRESS

WILSON POLICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2972		CERTIFICATE OF DEATH		Registered No. 67 2972		
1. NAME OF DECEASED (Type or Print) HENRY M. CALLSEN				2. DATE AND HOUR OF DEATH 26 March 1967 2:00 A. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines- Belair				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3709 Belair Rd.						
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 29 July 1892	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) san. dept.			10B. KIND OF BUSINESS OR INDUSTRY Aircraft Mfr.			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marry Callsen				14. MOTHER'S MAIDEN NAME Kate Schaefer						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-10-7680		17. INFORMANT ADDRESS Mrs. Katie Callsen, 3709 Belair Rd. 21206				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 420.0 I CONGESTIVE HEART FAILURE				CAUSE OF DEATH (A) DUE TO Myocardial Insufficiency (B) DUE TO Arteriosclerotic Heart Disease (C) DUE TO Thrombotic Pulmonary Embolism Uremic Heart Depletion				INTERVAL BETWEEN ONSET AND DEATH months " year. 3 mo. 3 mo.		
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (at hospital) attended the deceased from Jan 12 1967 to March 26 1967 , that (I) (we) last saw the deceased alive on March 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Albert B. Bradley				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3/27/67		
23C. PHYSICIAN'S NAME (Type) A.B. Bradley				23D. ADDRESS M.D. 4900 Belair Rd. 21206						
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3-29-67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore County, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967			25B. NAME OF REGISTRAR Robert S. Faldut			25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home, Baltimore, Md.				

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2973				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2973	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FINE, ADA (MRS)				2. DATE AND HOUR OF DEATH MARCH 26 1967 5 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Asburton Nursing Home 3520 Hilton St. Balto., Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 2803 Denison Street Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland D. STREET ADDRESS (If rural, give location) 2803 Denison Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/26/1879	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Bernard Sherry				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-48-2689		17. INFORMANT ADDRESS Morris Fine 444 S. 8th St. Chambersburg, Pa.			
18. 4200 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) HEART FAILURE DUE TO (B) ARTERIOSCLEROTIC HEART DISEASE DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH instantaneous 10 YEARS unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC BRAIN SYNDROME WITH ARTERIOSCLEROSIS							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1958 to MARCH 26 1967, that (I) (we) last saw the deceased alive on MARCH 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard D. HAHY				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/26/67	
23C. PHYSICIAN'S NAME (Type) RICHARD D HAHY				23D. ADDRESS M.D. 1010 Saint Paul St 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/37/67		24C. NAME of CEMETERY or CREMATORY Balto. Hebrew Congr. Cem.		24D. LOCATION (City, town, or county) (State) 2100 Belair Road Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR R. E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Jack Lewis, Inc. 2100 Eutaw Pl. Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2974		CERTIFICATE OF DEATH		Registered No. 67 2974	
1. NAME OF DECEASED (Type or Print) Bertie A. Haynie				2. DATE AND HOUR OF DEATH March 26, 1967 5:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing Home				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1418 Patapsco St. 23-02					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 18, 1889		9. AGE (In years last birthday) 78		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Willie Slater			14. MOTHER'S MAIDEN NAME Addie Schooler						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. George W. Haynie 1252 Battery Ave.				
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) UREMIA DUE TO (B) INTERCAPNARY GLOMERULOSCLEROSIS DUE TO (C) DIABETES MELLITUS				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHI PNEUMONIA									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3/15/67 19 to 3/26/67 19 that (I) (we) last saw the deceased alive on 3/26/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Harris JEANARINE M.D.				23B. DATE SIGNED 3/26/67		23C. PHYSICIAN'S NAME (Type) Harris JEANARINE M.D.			
23D. ADDRESS 930 WHITEHOCK ST.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3 29 67		24C. NAME of CEMETERY or CREMATORY Meadowridge		24D. LOCATION (City, town, or county) (State) Dorsey, Howard Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR G. E. Farley, M.D.		25C. FUNERAL DIRECTOR Mc Gully		25D. ADDRESS 130 E. Fort Ave			

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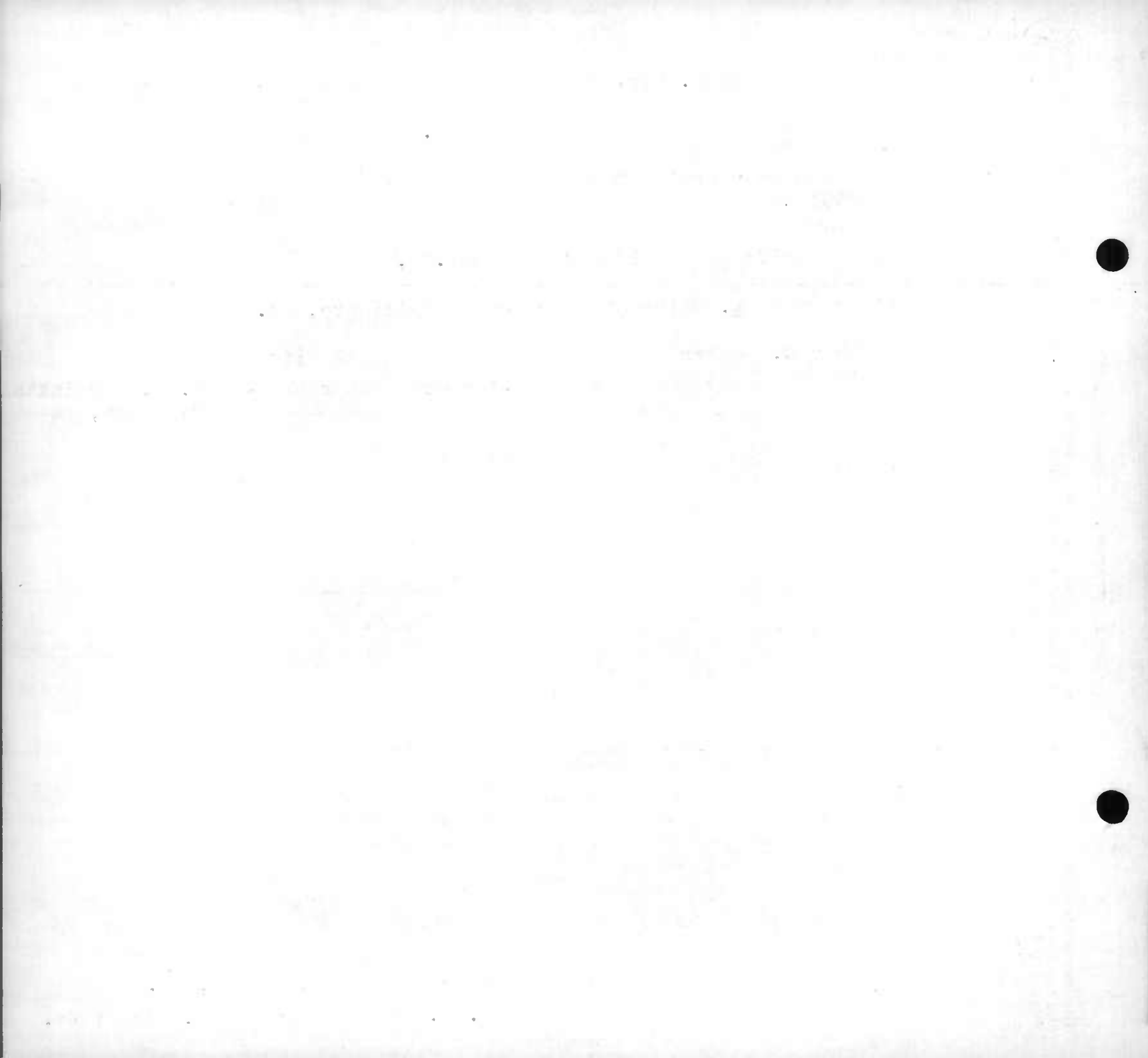
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2975				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2975	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Harry C. Becker				2. DATE AND HOUR OF DEATH March 23, 1967 4:20 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Kennesaw Nursing Home 2601 Roslyn Ave				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2916 Ellicott Drive			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 13, 1888	9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Drug Clerk		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Henry C. Becker	
14. MOTHER'S MAIDEN NAME Elizabeth Witcher			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	
17. INFORMANT Clarence Becker 6712-27th. ST. N			ADDRESS Arlington, Va.			18. 4 20.1 I	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Pulmonary Arteriosclerotic Coronary heart Disease				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Senility				INTERVAL BETWEEN ONSET AND DEATH Sudden			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION Feb 1 '67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hernia of Stomach		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1967 to March 23, 1967, that (I) (we) last saw the deceased alive on Mar 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE M. Paul Byerly				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) M. Paul Byerly				23D. ADDRESS 5820 York Rd		Baltimore 21212 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/67		24C. NAME of CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR H. W. Mears & Son		25C. FUNERAL DIRECTOR H. W. Mears & Son		ADDRESS 805 N. Calvert St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 2976	
BIRTH NO. 67 2976		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY MRS. MARY R. FLANIGAN		2. DATE AND HOUR OF DEATH MARCH 22, 1967 9:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 202 W. BELVEDERE AVE.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 202 E. BELVEDERE AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MAY 16, 1880	9. AGE (In years last birthday) 86 YRS.	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM H. ROTHROCK			14. MOTHER'S MAIDEN NAME MARGARET STAYLOR			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS 202 E. BELVEDERE AVE. PIERCE J. FLANIGAN JR.				
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arterio sclerotic cardio-vascular Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 50 to Present 19 67 , that (I) (we) last saw the deceased alive on 3/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Emmett Queen				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/23/67	
23C. PHYSICIAN'S NAME (Type) J. EMMETT QUEEN		23D. ADDRESS Medical Arts Bldg.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/25/67		24C. NAME of CEMETERY or CREMATORY CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Salisbury		25C. FUNERAL DIRECTOR ADDRESS H. W. MEARS & SON 805 N. CALVERT ST.			

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FUNERAL DIRECTOR: IMPORTANT

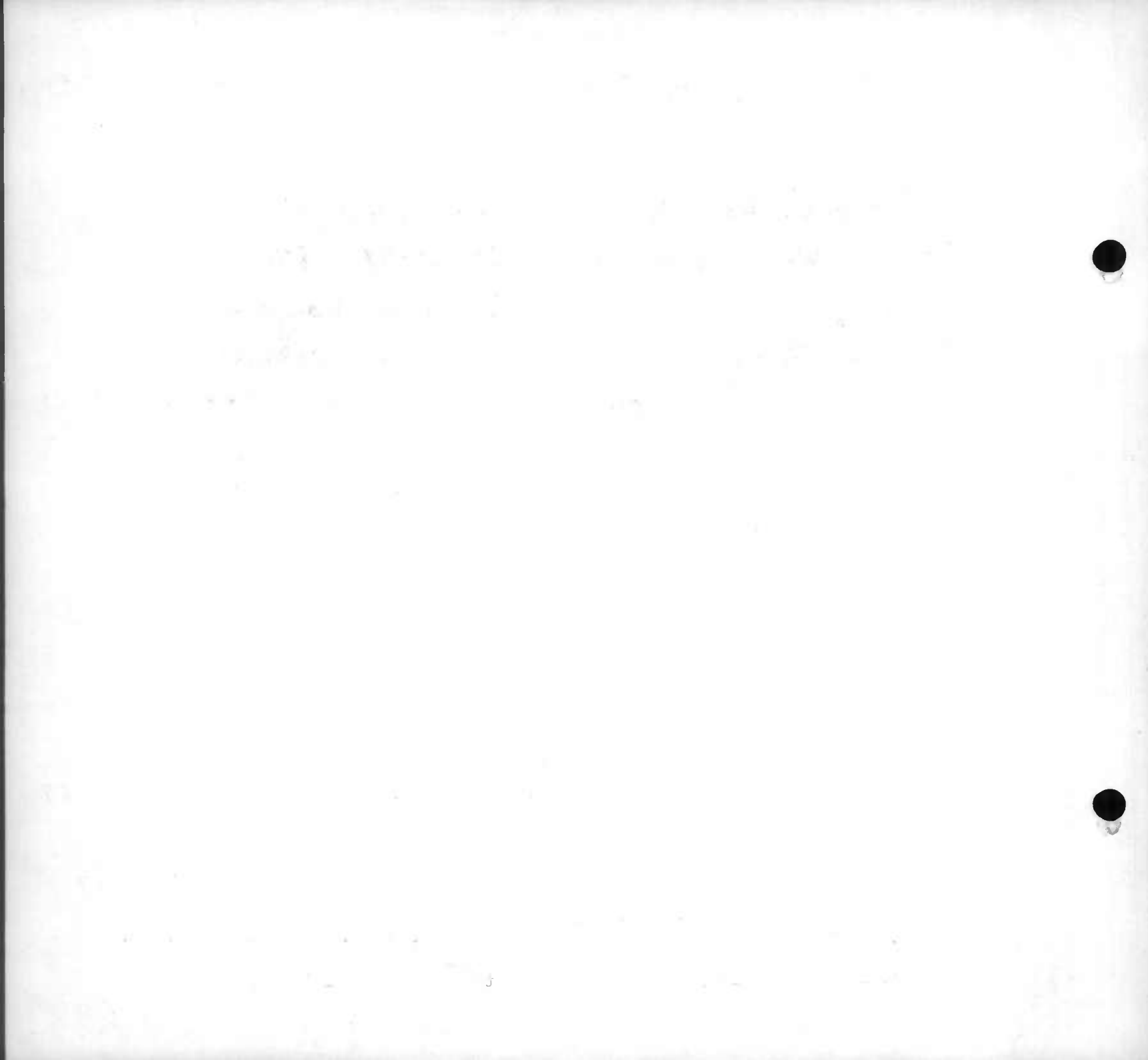
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 2977	
BIRTH NO. 67 2977		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Francis T. Crosbie		2. DATE AND HOUR OF DEATH 3/22/67 6:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 4601 Rokeby Rd Balto Md				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 4601 Rokeby Rd.			
5. SEX Male	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 29/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10B. KIND OF BUSINESS OR INDUSTRY Lord Balto. Hotel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Crosbie				14. MOTHER'S MAIDEN NAME Rose Aul			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-16-6267		17. INFORMANT Mrs. Francis T. Crosbie		ADDRESS 4601 Rokeby Rd. - 21229	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arterio sclerosis & ischemia + Coronary insufficiency 6 years				CAUSE OF DEATH Arterio sclerosis & ischemia + Coronary insufficiency 6 years			
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 7th 1967 to March 22 1967 , that (I) (we) last saw the deceased alive on Feb 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lee J. Voenick				23B. DATE SIGNED 3/23/67		23C. PHYSICIAN'S NAME (Type) Lee J. Voenick	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Witzke F.D.		ADDRESS 4101 Edmondson Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 2978		67 2978	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Schmidt, Mrs Charlotte			March 25, 1967 6 ¹⁵ a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
90 Keswick 700 W. 40th St.			Maryland 13-07		
5. SEX 7. F. 6. RACE W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
8. DATE OF BIRTH 12-23-79 9. AGE (In years last birthday) 87			D. STREET ADDRESS (If rural, give location) 700 W. 40th St.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Leonard Lehr		14. MOTHER'S MAIDEN NAME Christianna Schmidt		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-52-2437		17. INFORMANT ADDRESS Keswick Records 700 W 40th St.	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) DUE TO Hypertensive Cardiovascular Disease		
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 13 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 18 1959 to March 25 1967, that (I) (we) last saw the deceased alive on March 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger M.D.				23B. DATE SIGNED 3/25/67	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger M.D.				23D. ADDRESS 700 W. 40th. Street, Balto. Md. 21211	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm. J. Tubert Sons	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (State) Maryland			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2979	
BIRTH NO. 67 2979		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Carrie J. Boeckel		2. DATE AND HOUR OF DEATH March 25, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 General German Aged Home 22 S. Athol Ave.		A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 22 S. Athol Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Nov. 20/72	9. AGE (in years last birthday) 94	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME Charles F. Boeckel		14. MOTHER'S MAIDEN NAME Meta Dreyer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT General German Aged People's Home 22 S. Athol Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 334X1		CAUSE OF DEATH (A) Dehydration, Malnutrition DUE TO (B) Advanced Cerebral Arteriosclerosis DUE TO (C) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1965 to 25 March 1967 , that (I) (we) last saw the deceased alive on 25 March 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bryson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 25 March 67	
23C. PHYSICIAN'S NAME (Type) William J. Bryson		23D. ADDRESS 4605 Edmondson Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) 3-28-67-Burial		24B. DATE		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967			
25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.			

Page 1 of 1

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

436 67 2980		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2980	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
Herman Faister		3/26/67 2 A.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	
31		Maryland		Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224	
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)		6. STREET ADDRESS (If rural, give location)	
A. STATE		B. COUNTY		C. CITY OR TOWN	
Maryland		Baltimore		53-00	
D. STREET ADDRESS (If rural, give location)		7. DATE OF BIRTH		8. AGE (In years last birthday)	
726 Charing Cross Road 21229		8-27-1890		76	
9. SEX		10. RACE		11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White		Divorced	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country)	
Retired				Maryland	
15. FATHER'S NAME		16. MOTHER'S MAIDEN NAME		17. CITIZEN OF WHAT COUNTRY?	
George J.		Reith		U. S. A.	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT ADDRESS	
Unknown		216-09-3714-A		RECORDS: BCH 4940 Eastern Avenue 21224	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		22. CAUSE OF DEATH		23. INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		central ischemia	
ANTECEDENT CAUSES		(B) DUE TO		ASCVD + post op hematoma	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No)	
01/23/66		trigeminal neuralgia		NO	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		2/28 1967 to 3/24 1967.			
that (I) (we) last saw the deceased alive on		3/25 1967 and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
R. J. Owellen		3/26/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. R. J. Owellen		Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		March 29, 67		New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 28 1967		Robert E. Faister		Witzke Funeral Home 4101 Edmondson Ave.	



67 2981		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 2981	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) CARRIE MORGAN				2. DATE AND HOUR PRONOUNCED DEAD March 24, 1967 5:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 1638 Mountmor Ave.				A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1638 Mountmor Ave.	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH 12-25-1899	9. AGE (In years) 67	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) KING GEORGE CO., VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME TASKER TURNER				14. MOTHER'S MAIDEN NAME CASSIE TURNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Diane Riches 1638 Mountmor Court			
MEDICAL CERTIFICATION				18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease			
				ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO			
				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-25-67			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-29-67		23C. NAME of CEMETERY or CREMATORY Balto. Nat'l Cem.		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR Robert E. Fairbank		24C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens			

1
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BALTIMORE CITY HEALTH DEPARTMENT

67 2982
BIRTH NO. *67 2982* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2982
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MICHAEL PALMER		2. DATE AND HOUR PRONOUNCED DEAD March 25, 1967 9:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1617 N. Gilmore Street		15-01	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 4-24-1963
9. AGE (in years last birthday) 3-1/2		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CHILD	
11. BIRTHPLACE (State or foreign country) FLORENCE, SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLIFTON PALMER		14. MOTHER'S MAIDEN NAME AMEY MCALLISTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Amey Palmer		ADDRESS 232 Carey Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Asphyxia due to carbon monoxide		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Conflagration			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 3-25-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1617 N. Gilmore Street, 2nd Floor		21D. TIME OF INJURY (APPROX.) 3-25-67 8:15 A.M.	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Found in burning house	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-27-67	
23C. NAME of CEMETERY or CREMATORY Mount Auburn Cem.		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		24B. NAME OF REGISTRAR Philip E. Farley, M.D.	
24C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St	

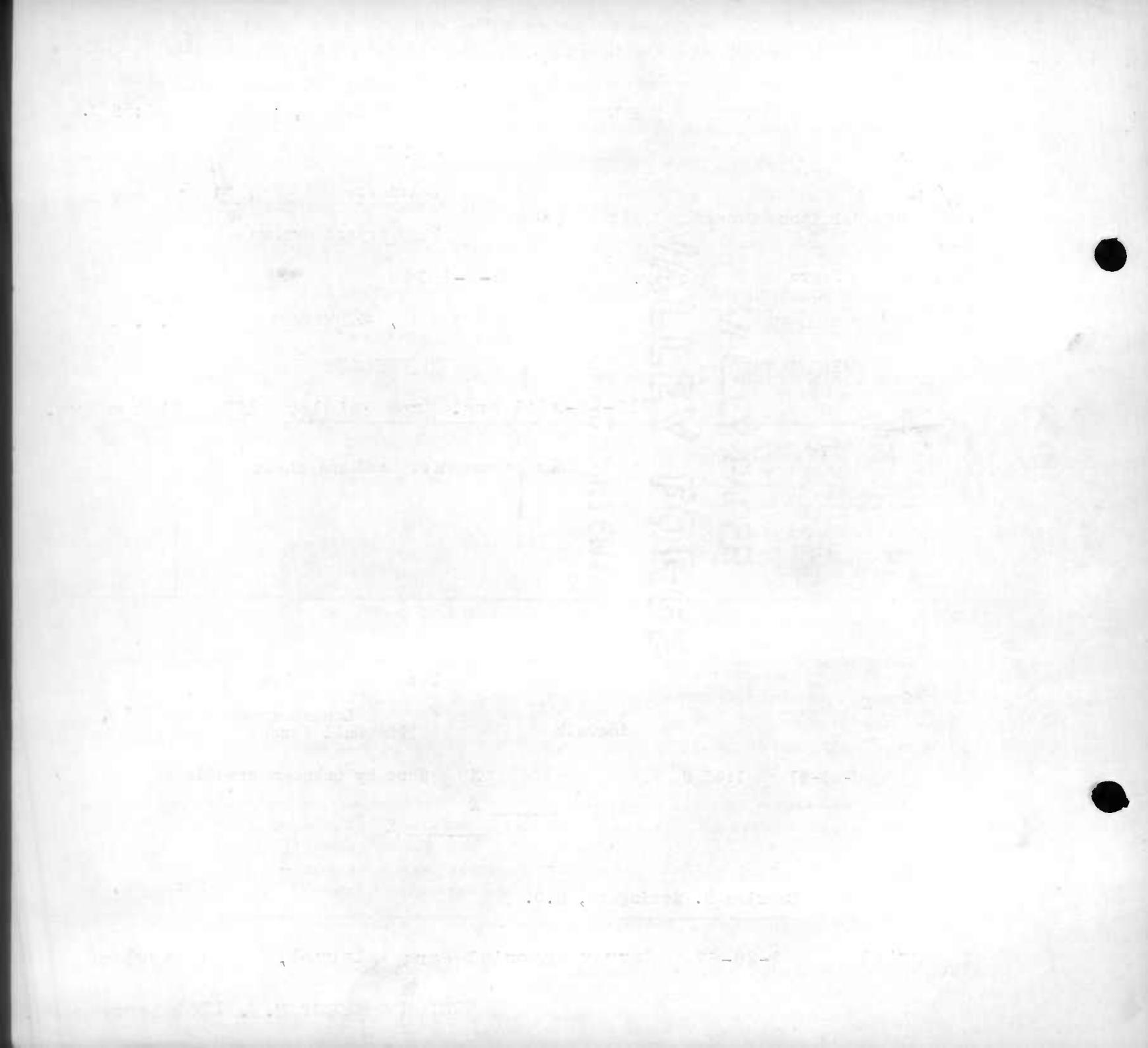
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F-34067 2983
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2983

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ELMER FAIDLEY				2. DATE AND HOUR PRONOUNCED DEAD March 25, 1967 1:55 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2200 Bryant Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-6-1934	9. AGE (In years last birthday) 32	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONG SHOREMAN			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		
13. FATHER'S NAME MARVIN HARRIS			14. MOTHER'S MAIDEN NAME EDITH FAIDLEY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-28-2545		17. INFORMANT ADDRESS Mrs. Erma Faidley 1536 Clifton Ave.		
18. E 98 IX I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of head and chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Longshoreman Union Hall, 1104 Hull Street			
21D. TIME OF INJURY (APPROX.) 3-25-67 1:45 P.M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Shot by unknown assailant			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 26, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-29-67	23C. NAME of CEMETERY or CREMATORY Carver Memorial Park		23D. LOCATION (City, town, or county) (State) Laurel, Maryland		
24A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		24B. NAME OF REGISTRAR Robert E. Finkbeiner		24C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.			



BIRTH NO.

67 2984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 2984

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HORACE THOMAS, JR.

2. DATE AND HOUR PRONOUNCED DEAD

March 25, 1967

9:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

310 N. Fulton Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

9-12-1937

9. AGE (In years
lost birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

POWER CON CORP.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HORACE THOMAS, SR.

14. MOTHER'S MAIDEN NAME

GRACE THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Bertina Lewis

1620 Balmor Court

18. E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest and abdomen
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

101 N. Payson Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3-25-67 6:05 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-30-67

23C. NAME of CEMETERY or CREMATORY

Mount Calvary Cem.

23D. LOCATION

(City, town, or county)

A.A.CO.,

Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 28 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

ADDRESS

1701 Laurens St.

UNCLASSIFIED

CONFIDENTIAL

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

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17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

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92. [Illegible]

93. [Illegible]

94. [Illegible]

95. [Illegible]

96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSHUA PRIDGEN

2. DATE AND HOUR PRONOUNCED DEAD

March 23, 1967 12:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1021 N. Bentalou Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

4-20-1903

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Xray Tech.

10B. KIND OF BUSINESS OR INDUSTRY

University Hosp.

11. BIRTHPLACE (State or foreign country)

NASHVILLE, NORTH CAROLINA U.S.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

LEM PRIDGEN

14. MOTHER'S MAIDEN NAME

MAGGIE STOKES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-28-7326

17. INFORMANT

ADDRESS

Mrs. Mamie Davis 774 S. 12th St. N.J.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/24/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-27-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park Arbutus,

23D. LOCATION

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 28 1967

Robert E. Farley

Morton & Dyett F.H. 1701 Laurens St.

THE OASIS

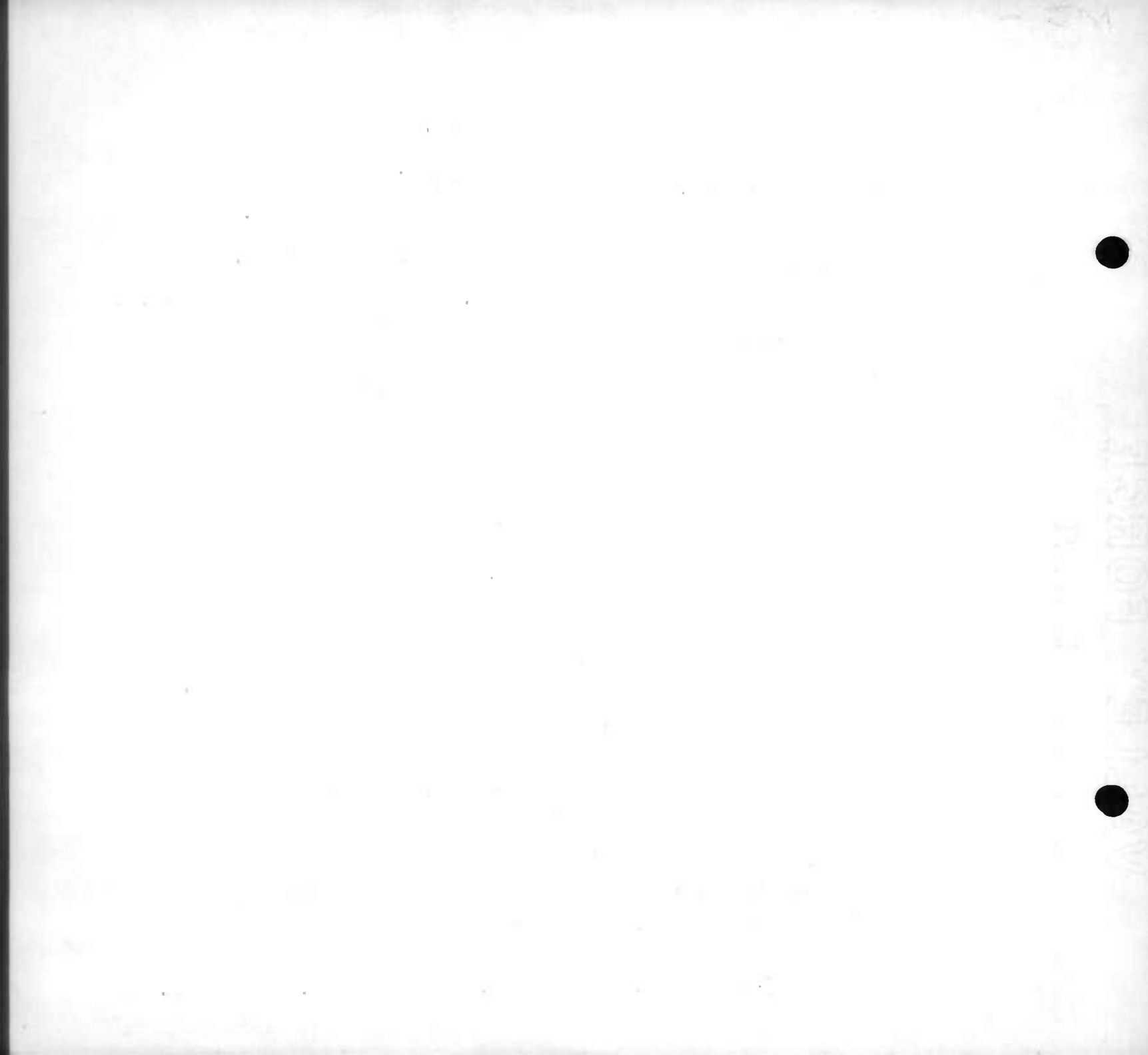
WILLIAM FORD

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2986		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2986	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Clifton Morris		3-25-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 2515 Quantico Ave.		(If not in hospital or institution, give street address or location)		Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.	
		D. STREET ADDRESS (If rural, give location) 2515 Quantico Ave.		15-13	
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10-12-97	9. AGE (In years last birthday) 69 yr.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sidney Morris		14. MOTHER'S MAIDEN NAME May	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214121045		17. INFORMANT Beatrice Gassaway 2515 Quantico Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Metastatic Carcinoma (B) DUE TO Carcinoma of Pancreas (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-2-1954 to 3-23-1967 , that (I) (we) last saw the deceased alive on 3-23-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Percival C. Smith M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3-27-67	
23C. PHYSICIAN'S NAME (Type) Percival C. Smith M.D.				23D. ADDRESS 1709 Gwynns Falls Pkwy	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-30-67		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE RECEIVED BY HEALTH DEPT. MAR 28 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2987	
<div>BIRTH NO. 67 2987</div> <div>CERTIFICATE OF DEATH</div>					
<div>M.E. CASE NO. (STRUGEL)</div> <div>1. NAME OF DECEASED (Type or Print) SCULLION, Mrs. ELIZABETH</div> <div>2. DATE AND HOUR OF DEATH March 26-67 4³⁰ AM</div>					
<div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSP.</div>			<div>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY</div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</div> <div>D. STREET ADDRESS (If rural, give location) 2715 FAIT AVE (24)</div>		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPERATED	8. DATE OF BIRTH 11. 9. 97	9. AGE (In years lost birthday) 69	<div>If Under 1 Yr. Months Days</div> <div>If Under 24 Hrs. Hours Min.</div>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10B. KIND OF BUSINESS OR INDUSTRY CANNING		11. BIRTHPLACE (State or foreign country) POLAND	12. CITIZEN OF WHAT COUNTRY? AMER.
13. FATHER'S NAME ALBERT STROGLE			14. MOTHER'S MAIDEN NAME SOPHIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMATION ADDRESS NEPHEW HENRY BAUFISMIDT CHURCH HOME	
<div>18. I</div> <div>CAUSE OF DEATH</div> <div>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> <div>19A. DATE OF OPERATION 4-20-71</div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div>20A. AUTOPSY? (Yes or No) No</div> <div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes</div> <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)</div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> <div>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</div> <div>21E. INJURY OCCURRED</div> <div>21F. HOW DID INJURY OCCUR?</div> <div>22. I certify that (I) (this hospital) attended the deceased from 3. 9. 1967 to 3. 26 1967, that (I) (we) lost saw the deceased olive on 3. 26. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> <div>23A. SIGNATURE [Signature]</div> <div>M.D. Attending Phys. Med. Director Staff Phys. [X]</div> <div>23B. DATE SIGNED 3-26-67</div> <div>23C. PHYSICIAN'S NAME (Type) Dr. A. Nathan</div> <div>23D. ADDRESS CH & H</div> <div>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</div> <div>24B. DATE 3/29/67</div> <div>24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM</div> <div>24D. LOCATION 6515 BOSTON ST, MD</div> <div>25A. DATE RECEIVED BY DEPT. MAR 28 1967</div> <div>25B. NAME OF REGISTRAR Robert E. Taylor</div> <div>25C. FUNERAL DIRECTOR Marie Jalkowsky</div> <div>25D. ADDRESS 800 KENNWOOD AVE</div>					

Handwritten text, possibly a title or header, mostly illegible due to fading.

Handwritten text, possibly a date or reference number, mostly illegible.

Several lines of handwritten text, possibly a list or a series of notes, mostly illegible.

Handwritten text, possibly a signature or a concluding note, mostly illegible.

Handwritten text at the bottom left corner, possibly a date or a reference number, mostly illegible.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 2988	
BIRTH NO. 67 2988		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Parker, Naomi		2. DATE AND HOUR OF DEATH 3/25/67 9:00 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL 601 N BROADWAY BALTIMORE, Md 21205		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2227 KIRK AVENUE			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/18/04	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JACOB KUHN		14. MOTHER'S MAIDEN NAME BEERING, ADLINE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-14-0734		17. INFORMANT ADDRESS Jane Washington-227 Kirk Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory arrest following spontaneous pneumothorax.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO ASCVD		INTERVAL BETWEEN ONSET AND DEATH 77 hr.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/22/67 19 to 3/25/67 19, that (I) (we) last saw the deceased alive on 3/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.H. Brown, III				23B. DATE SIGNED 3/25/67	
23C. PHYSICIAN'S NAME (Type) C.H. Brown, III				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/29/67		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967			
25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 2989	
BIRTH NO. 67 2989		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Louis Jefferson		25 Mar 67 425 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
48 Maryland Gen Hosp			Md		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Belt 20-07		
			D. STREET ADDRESS (If rural, give location)		
			224 Mt Healy		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	Negro	Widowed	6/16/00	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Longshoreman		Waterport		N.C. - Henderson	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Hed Jefferson			Tinny Saffel Chatman		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
			217 03 0073		Cleat
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
583X 14260X			(A) Pulmonary edema hepatitis		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C) DUE TO		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Diabetes Mellitus		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> 19 <u>67</u> to <u>3/22</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Daniel C Wilkerson				3/22/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Daniel C Wilkerson				421 Regester Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/30/67		Mount Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 28 1967		Robert E. Taylor		Herbert E. Nutter-3035 W. North Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2990		67 2990		REGISTERED NO.	
M.E. CASE NO.				1. NAME OF DECEASED	
(Type or Print)				ROLLINS WILLIAM C.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				3. 22 - 67 3:05 A.M.	
LUTHERAN HOSPITAL OF MARYLAND 46				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
A. STATE B. COUNTY				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
MARYLAND				BALTIMORE 13-11	
D. STREET ADDRESS (If rural, give location)				3712 BORMAN AVENUE	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED	
M		C		WIDOWED, DIVORCED (specify)	
				Not Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
UNKNOWN		Laborer Shipyard		11/14/04	
				9. AGE (In years most birthday)	
				60	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
MARYLAND		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Werner Rollins		Alice Gray		16. SOCIAL SECURITY NO.	
				17. INFORMANT ADDRESS	
				MRS BEASLEY 3228 TIOGA PKWY - 15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		BRAIN STEM HAEMORRHAGE	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3 - 19 - 1967 to 3 - 22 - 1967, that (I) (we) last saw the deceased alive on 3 - 22 - 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		V. Biswanath Pillai M.D.		3 - 22 - 67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
V. BISWANATH PILLAI		130 ASHBURTON STREET, BALTIMORE, Md 21206 LUTHERAN HOSPITAL OF MARYLAND.			
24A. BURIAL CREMATION, REMOVAL (specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/25/67		Centerville Cemetery	
24D. LOCATION (City, town, or county)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
Frederick, Md.		Joseph E. Russ		2322 W. North Ave. Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 28 1967		J. E. Russ		2322 W. North Ave. Baltimore, Md.	

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of doctor: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

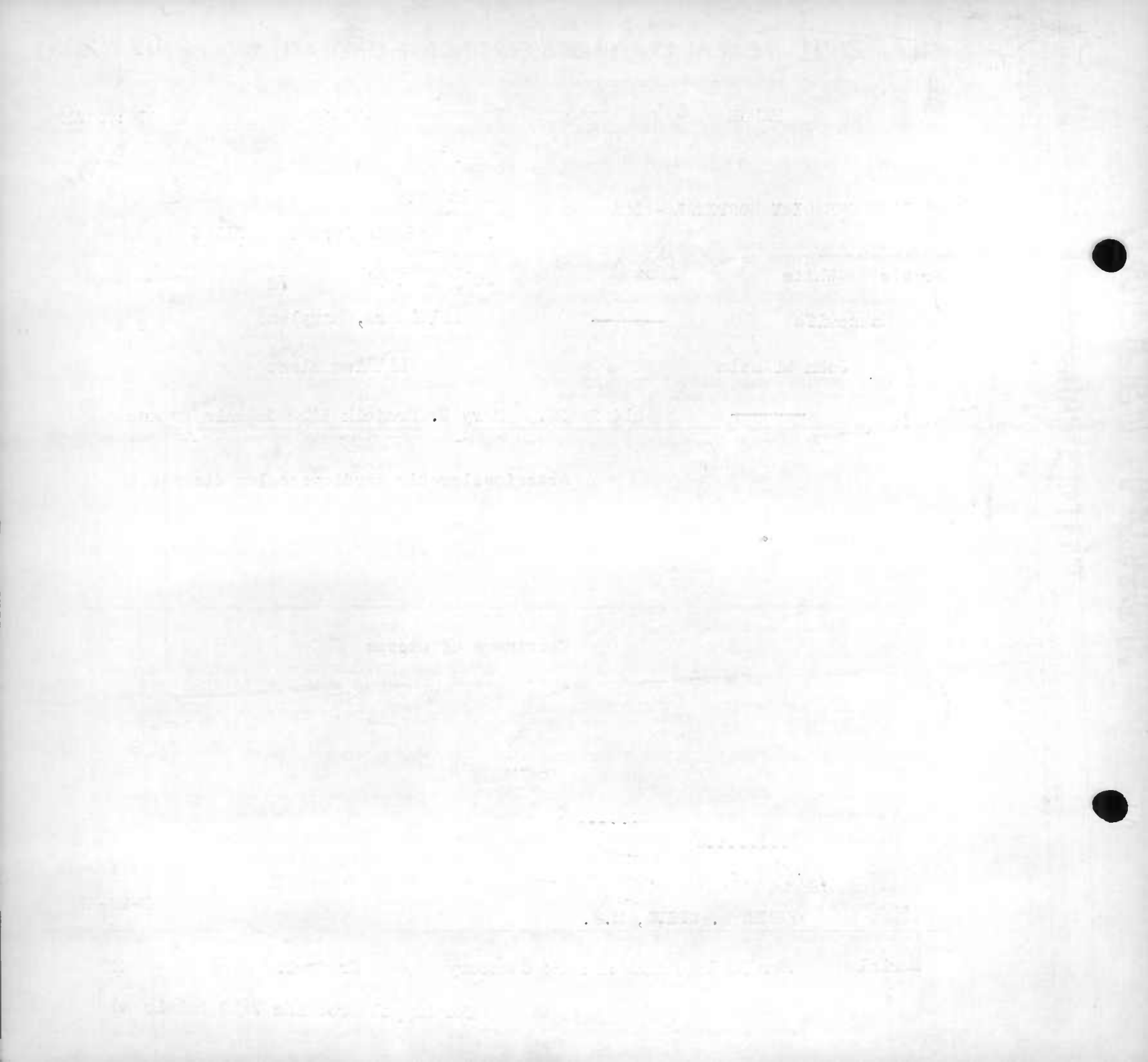
A-130

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2991

M.E. CASE NO.

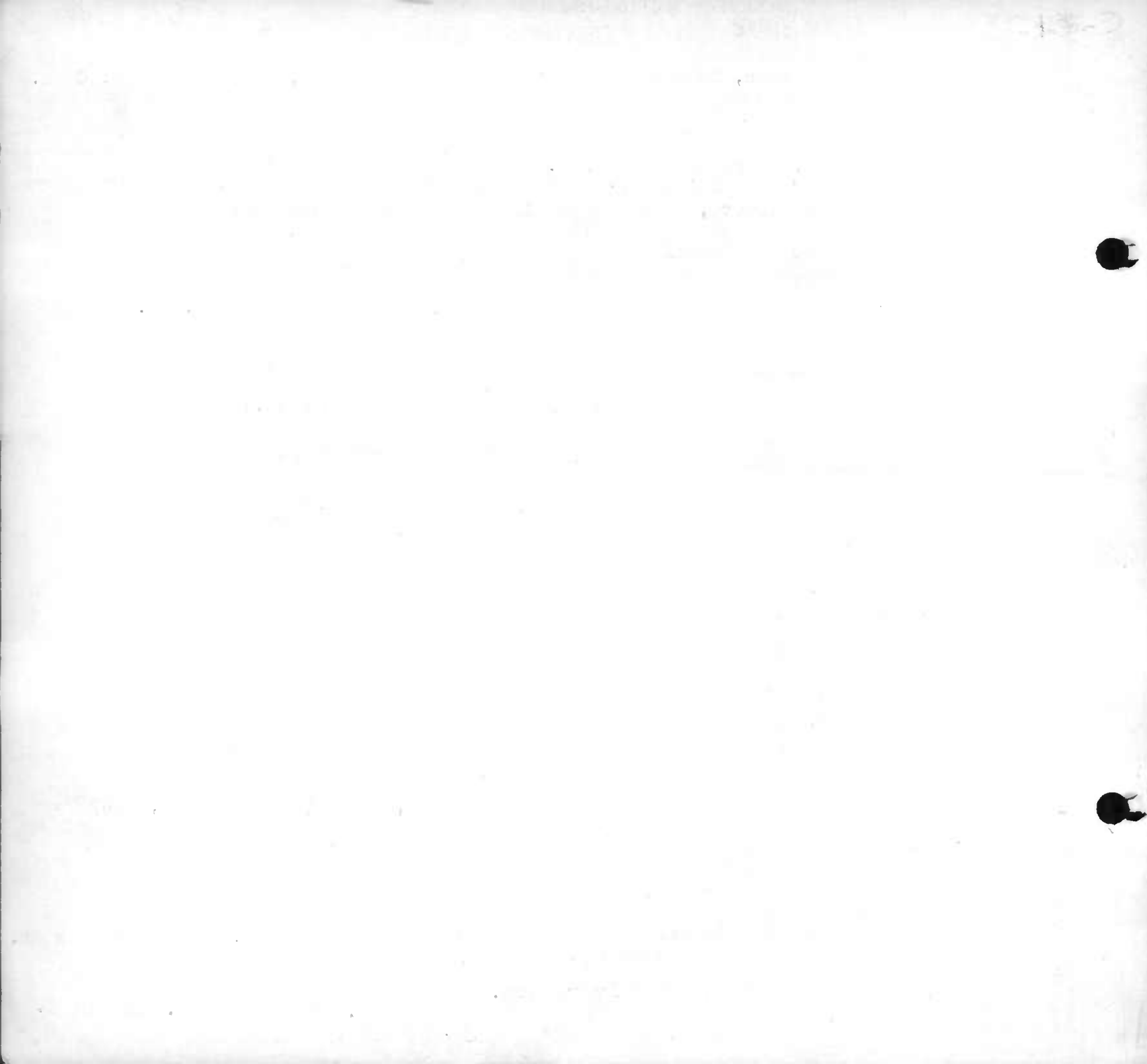
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
MAMIE B ABBOTT		3-27-67 10:25 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
31 BLATIMORE CITY HOSPITAL - DOA		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
99		D. STREET ADDRESS (If rural, give location) 5422 Cedonia Avenue 21206	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	White	Widowed	July 28 1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife			Baltimore, Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Wilhelm		Lillian Blake	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		214 20 2473	Mary C. Krejcik 5422 Cedonia Avenue
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Carcinoma of uterus	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	3-28-67
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Mar 30 1967	Loudon Park Cemetery	Frederick Road Md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAR 28 1967	Robert E. Farkas	The Dippel Bros Inc	7110 Belair Rd



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 2992		CERTIFICATE OF DEATH		Registered No. 67 2992	
1. NAME OF DECEASED (Type or Print) Gibson, Nellie				2. DATE AND HOUR OF DEATH March 22, 1967				2:00 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital Inc. 1514 Division Street Baltimore, Maryland #21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS 1006 North Calhoun Street					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 5/1/96	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-12-7581		17. INFORMANT William Gibson (hus.)		ADDRESS same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) Encephalomalacia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Pulmonary atelectasis Senility				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from February 10, 1967 to March 22, 1967 and that (I) (we) last saw the deceased alive on March 21, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. KHALIA				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) A. KHALIA		23D. ADDRESS Provident Hospital INC.- 1514 Division St.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/67		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Stetson D. Wilson					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 2993					Registered No. 67 2993				
BIRTH NO. 67 2993					CERTIFICATE OF DEATH				
M.E. CASE NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>MARIE M. SPIDELL</i>					3-25-67 1:50 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 MERCY HOSP.</i>					A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>				
					D. STREET ADDRESS (If rural, give location) <i>239 N. MILLON AVE</i>				
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>9-28-24</i>	9. AGE (In years lost birthday) <i>42</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>William H. Rappold, Sr.</i>					14. MOTHER'S MAIDEN NAME <i>Anna Breidback</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. James L. Spidell, Jr. 239 N. Milton Ave.</i>			ADDRESS	
18. <i>1750 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinomatosis, 1°</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>probably in ovary; metastasis to liver, bladder, colon, brain, lung & stomach</i>					CAUSE OF DEATH <i>Carcinomatosis, 1°</i> INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>3-18</i> 19 <i>67</i> to <i>3-25</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>3-25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Stephan J. Wittmann M.D.</i>					23B. DATE SIGNED <i>3-25-67</i>				
23C. PHYSICIAN'S NAME (Type) <i>STEPHAN J. WITTMANN M.D.</i>					23D. ADDRESS <i>MERCY HOSPITAL</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3-29-67</i>		24C. NAME of CEMETERY or CREMATORY <i>MT. CARMEL Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>BALTO., MD.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 28 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>			25C. FUNERAL DIRECTOR <i>Stephan J. Wittmann</i>			ADDRESS <i>2334 Jefferson St</i>	

APPOINTMENT

2-1 4-10-9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 2994		Registered No. 67 2994	
BIRTH NO. 67 2994		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 3-25-67		M.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>THOMAS J. HOHMAN</u>				2. DATE AND HOUR OF DEATH 3-25-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MERCY HOSPITAL</u>				A. STATE <u>MARYLAND</u>			
37				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>3339 ELMLEY AVE.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>5-15-1907</u>	9. AGE (in years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PAINTING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AUGUST A. HOHMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNA L. ROUTHHAUPT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-3138</u>		17. INFORMANT <u>Mrs. Catherine L. Johnson - 3339 Elmley Ave.</u>		ADDRESS	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>Central Respiratory Depression</u> DUE TO			
				(B) <u>Uremic + Hypertensive Encephalopathy</u> DUE TO			
				(C) <u>Uremia 2° to Nephrosclerosis</u>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>(1) Pneumonia, LUL (2) Acute Anterior MI</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> 19 <u>67</u> to <u>3/25</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> 19 <u>67</u> and that in (my) the opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael A. Ellis</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/25/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael A. Ellis</u>				23D. ADDRESS M.D. <u>Mercy Hospital Balto Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-30-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 28 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Charles Miller - 2334 Jefferson St.</u>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2995				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2995	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Sister Mary Matthew Duggan, OSS				3/25/1967 9:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
94 St. Elizabeth's Convent		3725 Ellerslie Ave.		Maryland		Baltimore	
5. SEX				6. RACE			
F				W			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Never Married				3/4/1888			
9. AGE (In years last birthday)				10. AGE (In years last birthday)			
79				79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Nun				Dublin, Ireland			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Religious				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Michael Duggan				Mary Daly			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No							
17. INFORMANT				ADDRESS			
Mother Mary Gerrard				(Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				6 mos.			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
(APPROX.)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from Oct. 5 1966 to Mar. 25 1967, that (I) (we) last saw the deceased alive on Mar. 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				23B. DATE SIGNED			
23A. SIGNATURE				23D. ADDRESS			
Com. H. Kammer, Jr. M.D.				6011 York Road			
23C. PHYSICIAN'S NAME (Type)				25C. FUNERAL DIRECTOR			
William H. Kammer, Jr. M.D.				H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				3/28/67			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
St. Elizabeth's Convent Chapel, Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
MAR 28 1967				R. E. Jenkins			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2996		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2996	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM PAUL MORONEY		2. DATE AND HOUR OF DEATH 3-25-67 8 4 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND HOSPITAL OR INSTITUTION Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-48	
6. SEX M		7. RACE W		8. DATE OF BIRTH 1897 05-21-95	
9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		10. AGE (In years last birthday) 69-71		11. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SUPER.		10B. KIND OF BUSINESS OR INDUSTRY RACE TRACK		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MICHAEL MORONEY		14. MOTHER'S MAIDEN NAME NELLIE LOVETT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-03-5371A		17. INFORMANT MR. CLARENCE A. MORONEY (SAME)	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR ACCIDENT		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 03-24 1967 to 03-25 1967 , that (I) (we) last saw the deceased alive on 03-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 03-25-67		23C. PHYSICIAN'S NAME (Type) DR ZOLTAN ZARDAY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/1967		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co		25D. ADDRESS 4905 York Rd Balto. 12, Maryland		25E. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2997				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 56-46-65	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Berger, Anna Kim BALL</u>				2. DATE AND HOUR OF DEATH <u>3/27/1967</u> <u>12:35 AM</u>			
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto Co</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4 Union Memorial Hospital</u> <u>33rd & Calvert Sts. Balto. 2/2/8</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>2/2/0</u> <u>53-00</u>			
D. STREET ADDRESS (If rural, give location) <u>6106 Bellinham Court</u>							
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Married</u>	B. DATE OF BIRTH <u>10/30/91</u>	9. AGE (In years lost birthday) <u>75</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Vernon Kimball</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta J. Hepburn</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-46-4885</u>		17. INFORMANT ADDRESS <u>Husband: Mr. Herman W. Berger</u> <u>6106 Bellinham Court Balto</u>		
18. <u>201X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hodgkins Disease</u>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3/11/67 - 3/27/67</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>pernicious anemia & cachexia</u>				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month) 1 Day) 1 Year) 1 Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> 19 <u>67</u> to <u>March 27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 26</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Francis X. Carmody</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>George McLean</u>				23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/30/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 28 1967</u>		25B. NAME OF REGISTRAR <u>R. E. E. F. F. F.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.</u>			

George McLean
James - X

March 26
March 11

X

March 27

March 27

Providence Avenue & Oak
Hopkins Avenue
March 27 - 28

March 27 - 28
Hopkins Avenue
March 27 - 28

George Warner Kinball
Housewife

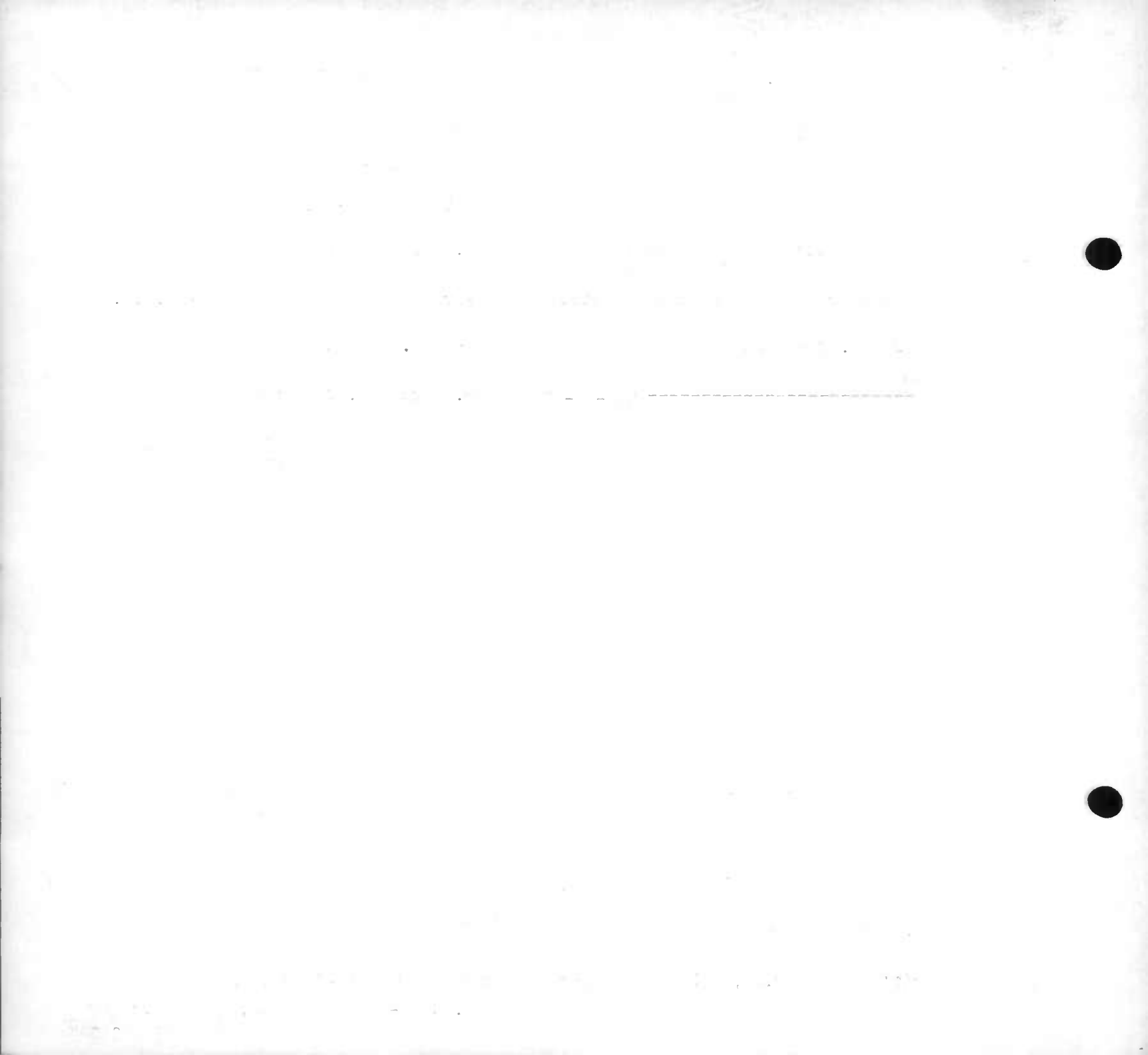
March 27
March 27

March 27 - 28
Hopkins Avenue
March 27 - 28

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2998		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 2998	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ROY E. THOMPSON				2. DATE AND HOUR OF DEATH March 27, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21211 D. STREET ADDRESS (If rural, give location) 3625 Roland Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 13, 1894	9. AGE (In years last birthday) 73 Years	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Western Electric		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Mark H. Thompson			14. MOTHER'S MAIDEN NAME Sarah E. Martin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-9249		17. INFORMANT ADDRESS Mrs. Myrtle L. Thompson, Same as # 4	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 20 years 20 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 10/1 1963 to 11/28 1966, that (I) last saw the deceased alive on 11/28 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did not) view the body after death.					
23A. SIGNATURE Robert W. Gebhardt M.D.				23B. DATE SIGNED 3/27/1967	
23C. PHYSICIAN'S NAME (Type) ROBERT W. GEBHARDT		23D. ADDRESS M.D. 1211 NORTHERN PKWY. BALTO, MD 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar. 30, 1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967			
25B. NAME OF REGISTRAR J. E. Johnson		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 2999				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 2999	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Frank Allen Jones, Sr.</i>		2. DATE AND HOUR OF DEATH <i>March 27, 1967 2:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balts Co.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>				D. STREET ADDRESS (If rural, give location) <i>7720 Greenview Terr.</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>7/30/05</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Vice-president</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. Spice Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Anton Jones</i>				14. MOTHER'S MAIDEN NAME <i>ANNA Blume</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>170-03-6146</i>		17. INFORMANT <i>Mrs. Ruth Jones</i>		ADDRESS <i>Same as #4</i>			
18. <i>165 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Metastatic Carcinoma lung,</i> DUE TO <i>origin undetermined</i> (B) <i>Metastatic carcinoma liver,</i> DUE TO <i>origin undetermined</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i> <i>2 mo</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>3/9</u> 19 <u>67</u> to <u>3/27</u> 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>3/27</u> 19 <u>67</u> and that in (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.									
23A. SIGNATURE <i>W. Michael Gould</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/27/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>W. Michael Gould</i>				23D. ADDRESS <i>Md. General Hospital</i>					
24A. BURIAL CREMATION, (Specify) <i>Entombment</i>		24B. DATE <i>Mar. 31, 1967</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Mausoleum</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Maryland</i>			
25A. DATE RECEIVED <i>MAR 28 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Schuyler</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland</i>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 3000	
CERTIFICATE OF DEATH					
BIRTH NO. 67 3000		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		CLARE O. FECHTIG		2. DATE AND HOUR OF DEATH 3/25/67 3-A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home 115 E. Melrose Ave		A. STATE Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 115 E. Melrose Ave.			
5. SEX Female	6. RACE Cau	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 20, 1875	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Philadelphia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph M. Oliver		14. MOTHER'S MAIDEN NAME Mary B. Philips			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. GORDON CARROLL	
				ADDRESS Weston, Conn.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 450.01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Atherosclerosis (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1957 to March 1967 that (I) (we) lost saw the deceased alive on 3-24-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-27-67	
23C. PHYSICIAN'S NAME (Type) William G. Helfrich		23D. ADDRESS M.D. 5006 Roland Avenue # 21210			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/67		24C. NAME of CEMETERY or CREMATORY Lorraine Park	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Balt. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 28 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md.	

